Implementing and Monitoring the VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus in the Primary Care Setting to Improve the Health of Our Population

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26 April 2005

Guideline Implementation Checklist

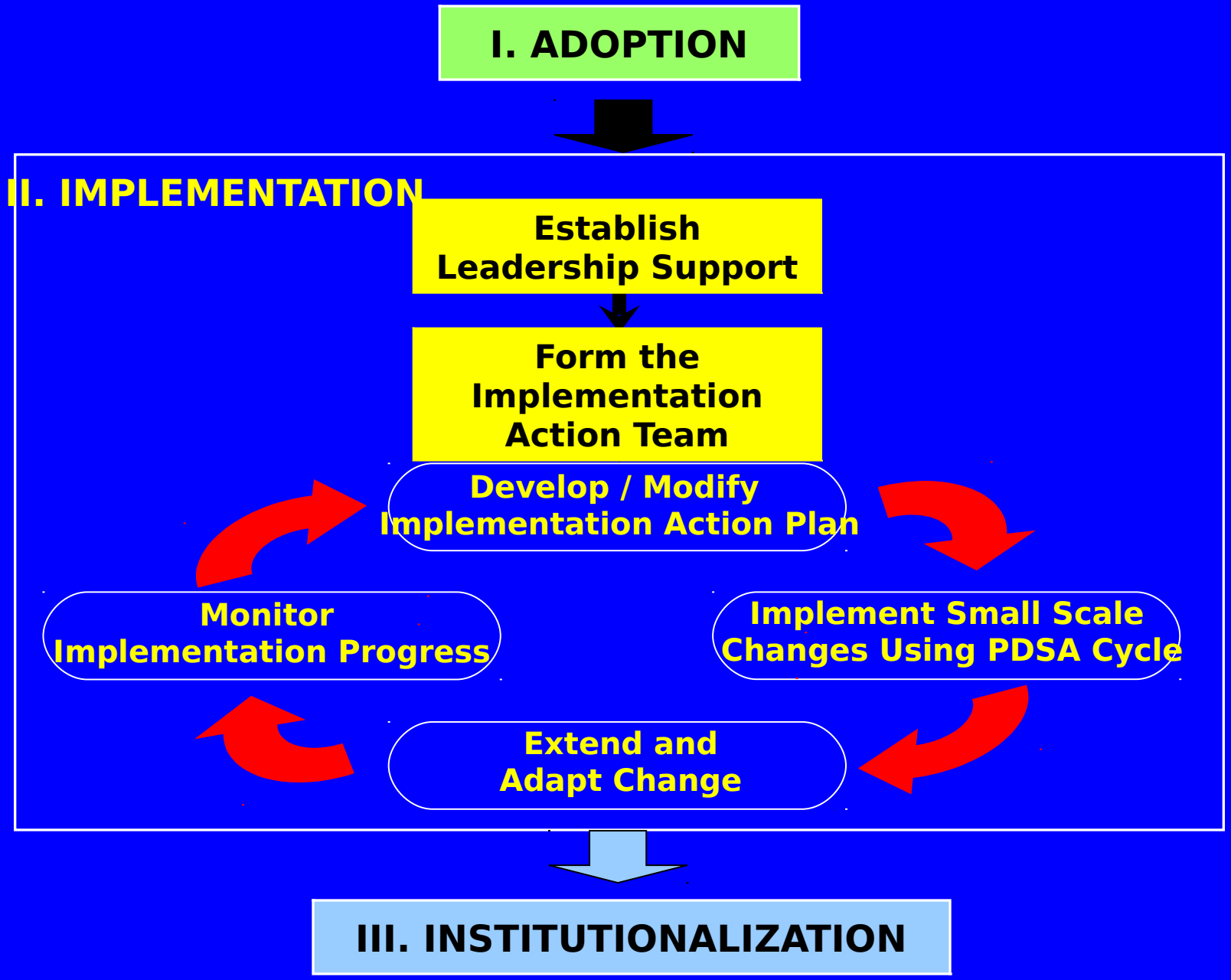
- **Assessment of Level of Effort: Look at Data**
- **Champion Designation**
- **Team Formation**
- **Action Plan Formulation/Implementation**
  - **Healthcare Team Education**
  - **Clinic Process Changes**
  - **Patient Self-management Education**
  - **Metrics and Monitoring**
    - **Rapid-cycle change**
- **Integration into MTF Processes: Institutionalization**
  - **Education: Orientation, Birth Month, Credentials Clerk**
  - **Monitoring: Peer Review, UM/QM, Executive Committee**

Facility Implementation Team

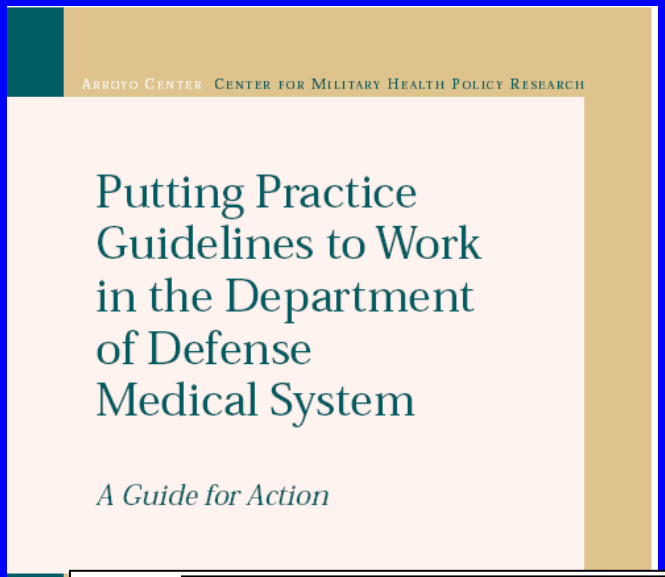
- Guideline Champion
  - The person with clinical expertise in the guideline who acts as an advocate for implementation
  - Belief in the value of clinical practice guidelines
  - Of sufficient rank to facilitate authoritative action
- Other team members
  - Condition Specialists, Primary Care Providers, Nurse Practitioners, Physicians' Assistants
  - Nurses, Pharmacists, Physical Therapists, Dieticians
  - Administrative staff
  - Ancillary support staff
  - Quality Management staff
- Group Facilitator, usually Quality Management Staff

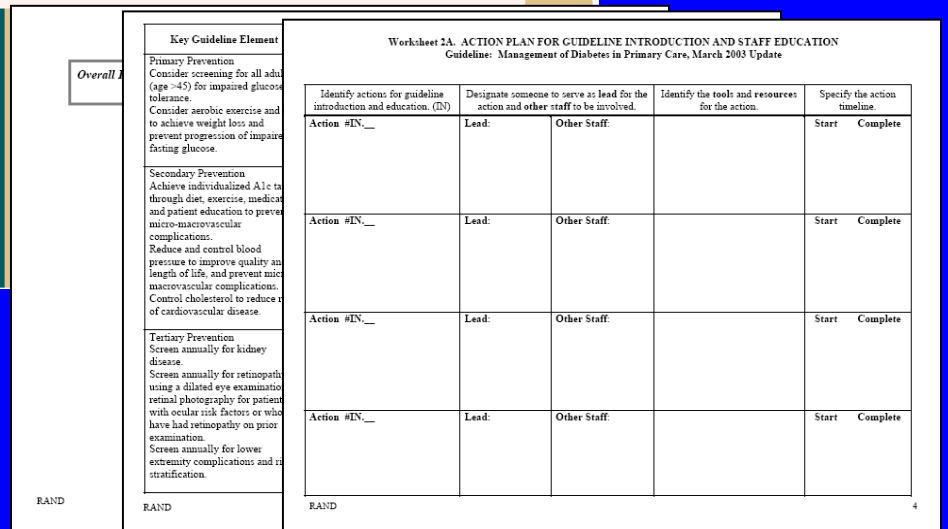
Working as a Team

- Integrate CPGs into routine clinic processes done by all staff (primary care providers, ancillary personnel, pharmacy staff, dieticians, physical therapists, Health Promotion staff, etc)
  - Screening
    - Universal screens for tobacco use, pain, depression & post-deployment health concerns
    - Time-specific screens
  - Patient questionnaire administration
  - Patient education opportunities
  - Standing orders for guideline conditions
  - Follow-up care
  - Group visits


I. ADOPTION
II. IMPLEMENTATION
Establish Leadership Support
Form the Implementation Action Team
Develop / Modify Implementation Action Plan
Implement Small Scale Changes Using PDSA Cycle
Extend and Adapt Change
Monitor Implementation Progress
III. INSTITUTIONALIZATION

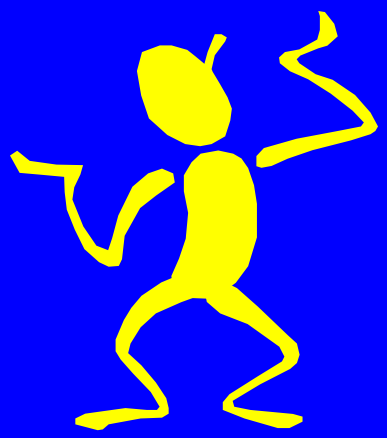
DM CPG
Team Member Responsibilities:
Be a Part of Your Clinic's DM CPG Team


Arroyo Center Center for Military Health Policy Research
Putting Practice Guidelines to Work in the Department of Defense Medical System
A Guide for Action


Key Guideline Element
Primary Prevention
Secondary Prevention
Tertiary Prevention
RAND
Worksheet 2A. ACTION PLAN FOR GUIDELINE INTRODUCTION AND STAFF EDUCATION
Guideline: Management of Diabetes in Primary Care, March 2003 Update
Identify actions for guideline introduction and education. (IN)
Designate someone to serve as lead for the action and other staff to be involved.
Identify the tools and resources for the action.
Specify the action timeline.
Action #IN.__
Lead:
Other Staff:
Start
Complete
RAND
4

- **Use the AMEDD/RAND <u>Implementing Clinical Practice Guidelines in the Department of Defense</u> and Team Worksheets (both contained in the tool kit binder) to guide your DM CPG Implementation Team's efforts.**

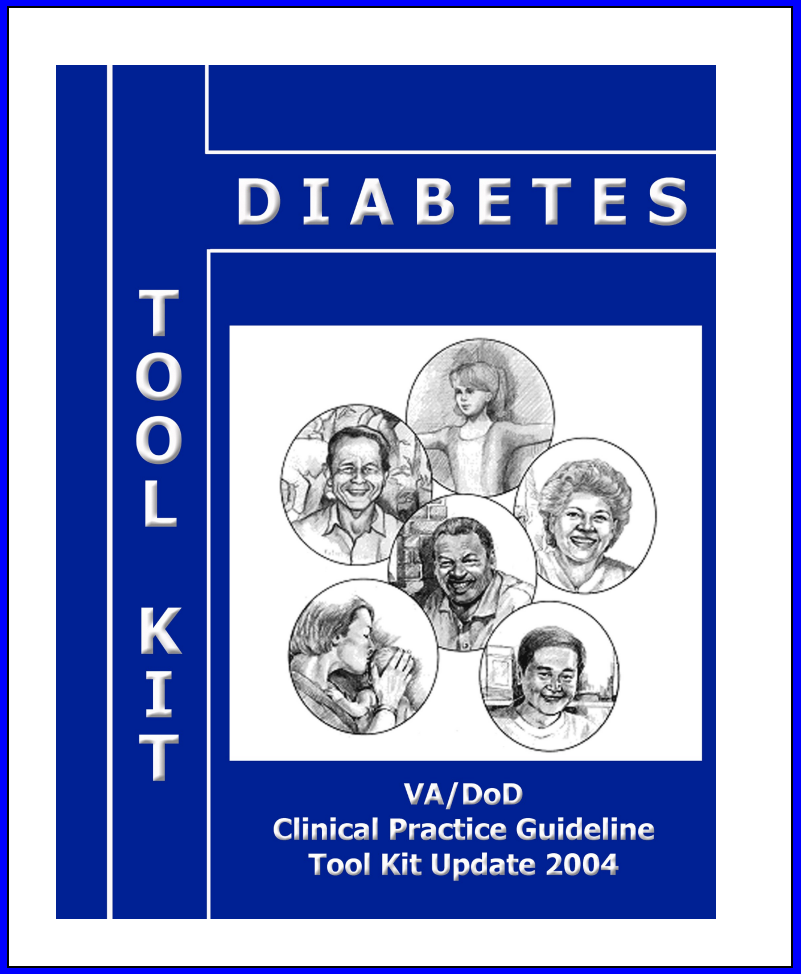
What can we do to make the VA/DoD Diabetes Guideline happen in our clinic?

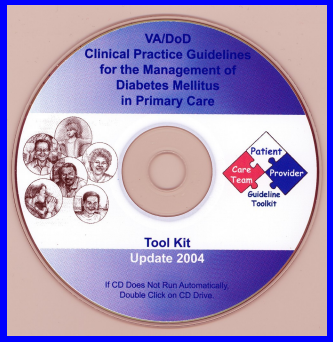


The Diabetes CPG Tool Kit

How Does the Tool Kit support Guideline Implementation?

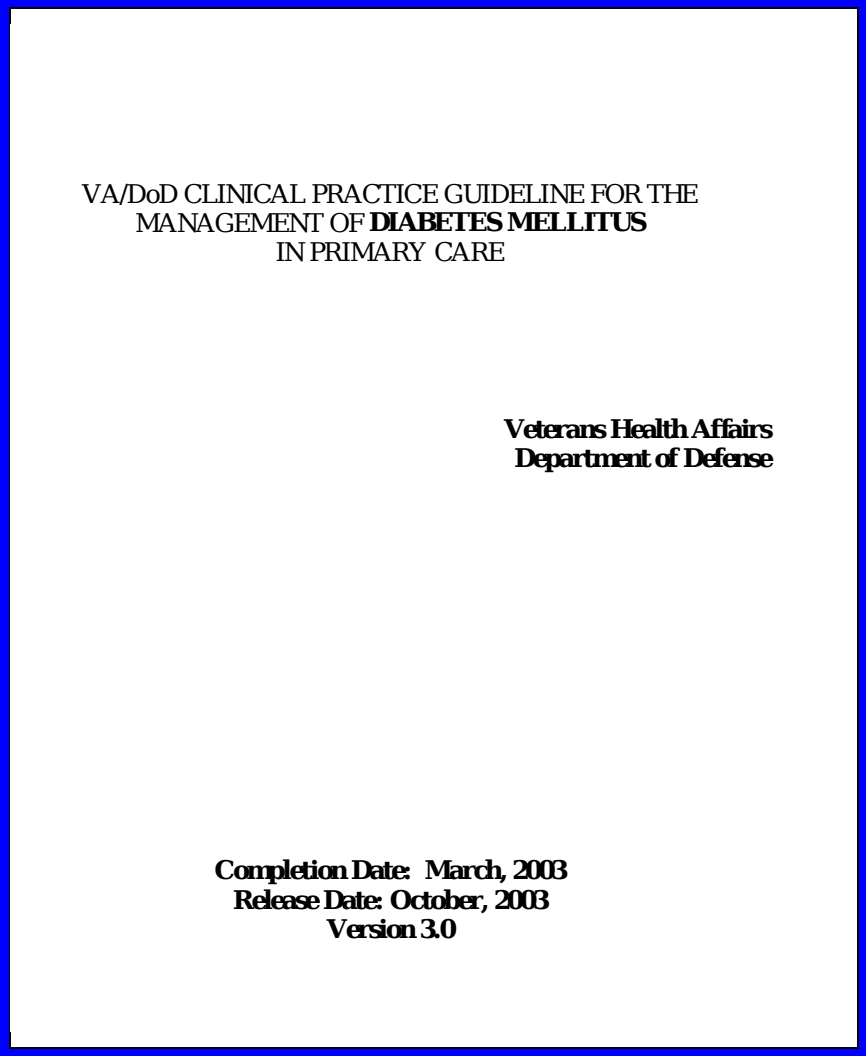
The Diabetes Toolkit





- Diabetes Binder and CDROM
- Provider Support Tools
- Patient Self-Management Tools
- System Support Tools

Diabetes Mellitus Guideline


VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE
MANAGEMENT OF **DIABETES MELLITUS**
IN PRIMARY CARE

Veterans Health Affairs
Department of Defense

Completion Date: March, 2003
Release Date: October, 2003
Version 3.0

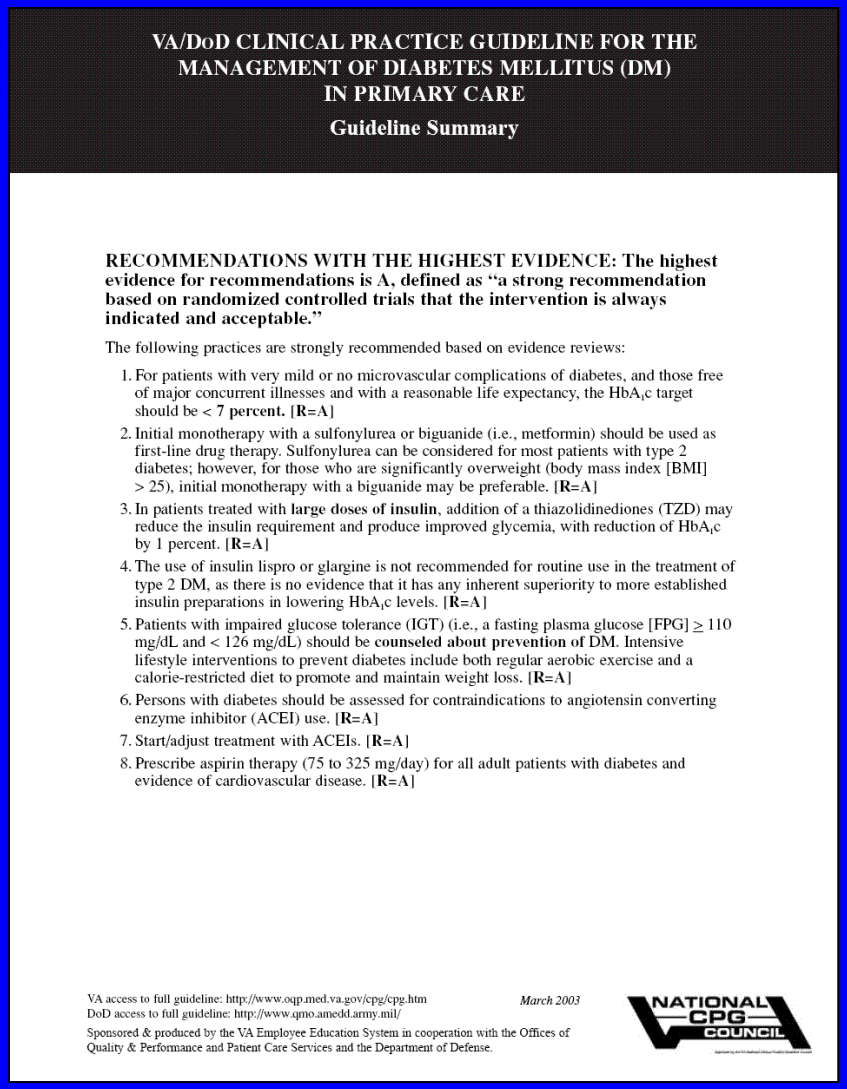
Web version available online at:

http://www.oqp.med.va.gov/cpg/DM/DM_base.htm

Also available online at:

http://www.QMO.amedd.army.mil

Diabetes Mellitus Guideline Summary



VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF DIABETES MELLITUS (DM) IN PRIMARY CARE

Guideline Summary

RECOMMENDATIONS WITH THE HIGHEST EVIDENCE: The highest evidence for recommendations is A, defined as "a strong recommendation based on randomized controlled trials that the intervention is always indicated and acceptable."

The following practices are strongly recommended based on evidence reviews:

1. For patients with very mild or no microvascular complications of diabetes, and those free of major concurrent illnesses and with a reasonable life expectancy, the HbA_1c target should be < **7 percent.** [**R=A**]
2. Initial monotherapy with a sulfonylurea or biguanide (i.e., metformin) should be used as first-line drug therapy. Sulfonylurea can be considered for most patients with type 2 diabetes; however, for those who are significantly overweight (body mass index [BMI] > 25), initial monotherapy with a biguanide may be preferable. [**R=A**]
3. In patients treated with **large doses of insulin**, addition of a thiazolidinediones (TZD) may reduce the insulin requirement and produce improved glycemia, with reduction of HbA_1c by 1 percent. [**R=A**]
4. The use of insulin lispro or glargine is not recommended for routine use in the treatment of type 2 DM, as there is no evidence that it has any inherent superiority to more established insulin preparations in lowering HbA_1c levels. [**R=A**]
5. Patients with impaired glucose tolerance (IGT) (i.e., a fasting plasma glucose [FPG] ≥ 110 mg/dL and < 126 mg/dL) should be **counseled about prevention** of DM. Intensive lifestyle interventions to prevent diabetes include both regular aerobic exercise and a calorie-restricted diet to promote and maintain weight loss. [**R=A**]
6. Persons with diabetes should be assessed for contraindications to angiotensin converting enzyme inhibitor (ACEI) use. [**R=A**]
7. Start/adjust treatment with ACEIs. [**R=A**]
8. Prescribe aspirin therapy (75 to 325 mg/day) for all adult patients with diabetes and evidence of cardiovascular disease. [**R=A**]

VA access to full guideline: http://www.oqp.med.va.gov/cpg/cpg.htm
DoD access to full guideline: http://www.qmo.amedd.army.mil/

March 2003

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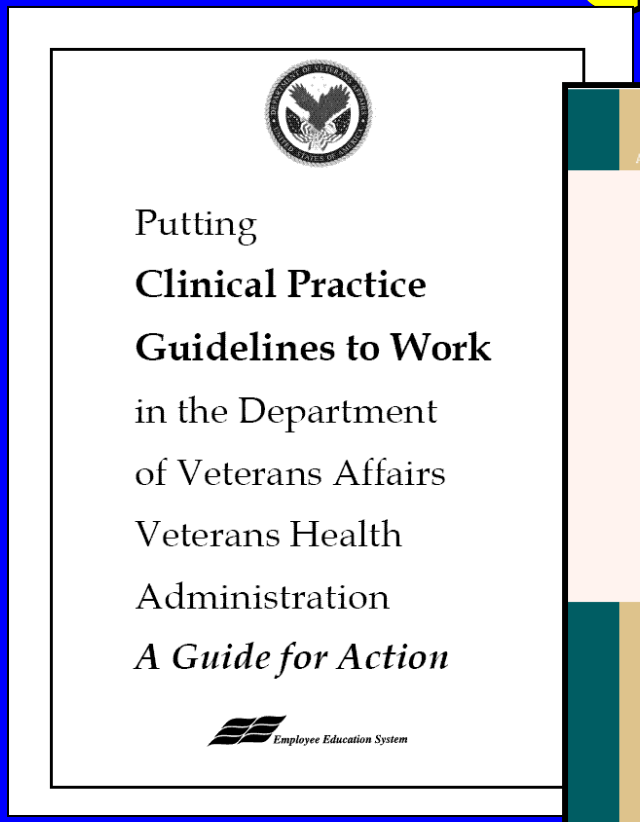
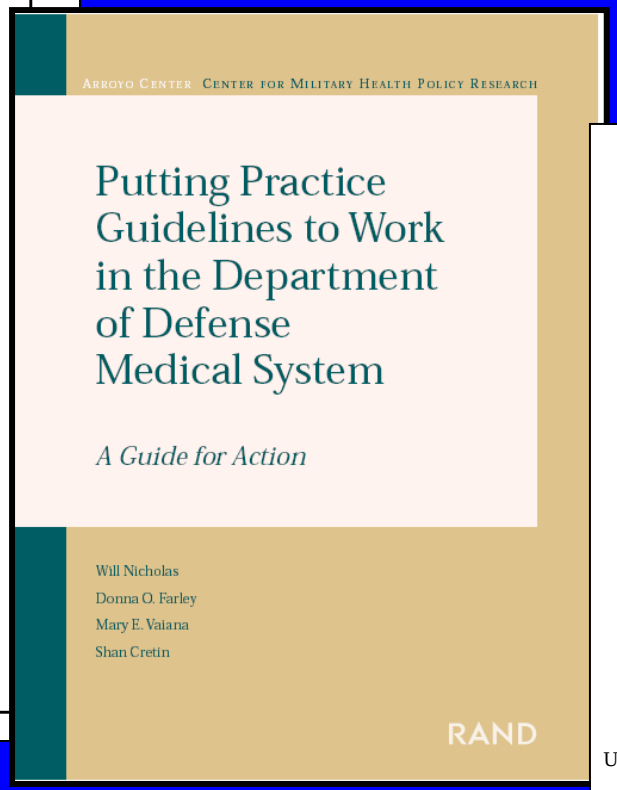
NATIONAL CPG COUNCIL

- **Recommendations with the Highest Evidence**
- **Guideline Key Elements**
- **Module D – Core Components**
- **Module S – Screening**
- **Module G - Glycemic Control**
- **Module E – Eye Care**
- **Module F – Foot Care**
- **Module R – Kidney Function**
- **Module M – Self**

Manuals for Facility Clinical Practice Guideline Champions



VA Implementation Manual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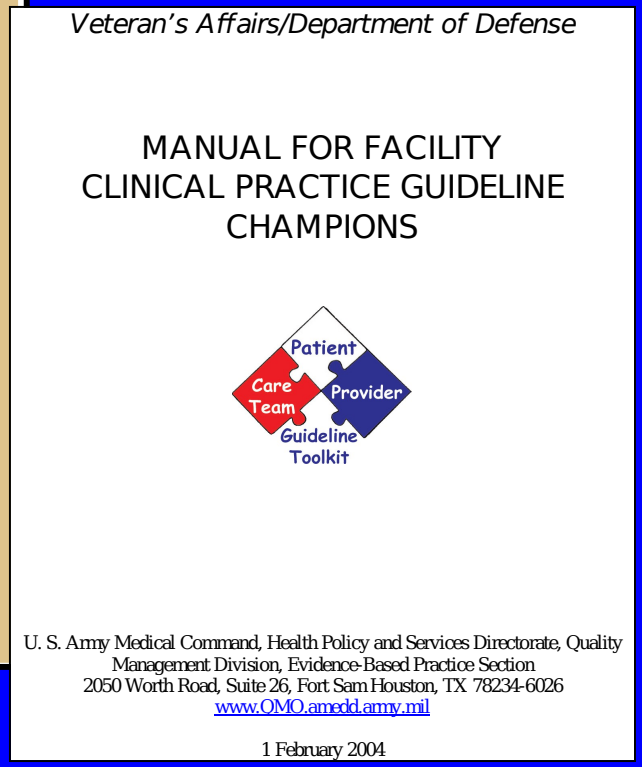
Shan Cretin
RAND

RAND Implementation Manual



DoD Implementation

Implementation Worksheets

Worksheet 1. IMPLEMENTATION STRATEGY
Guideline: Management of Diabetes in Primary Care, March 2003 Update

Overall Implementation Strategy/Focus:

Key Guideline Element	Gaps in Current Practices	Action Strategy
Primary Prevention Consider screening for (age >45) for impaired tolerance. Consider aerobic exerc to achieve weight loss prevent progression of fasting glucose.		
Secondary Prevention Achieve individualized through diet, exercise, and patient education t micro-macrovascular complications. Reduce and control blo pressure to improve qu length of life, and prev macrovascular complic Control cholesterol to of cardiovascular disea		
Tertiary Prevention Screen annually for kid disease. Screen annually for ret using a dilated eye exa retinal photography for with ocular risk factors have had retinopathy o examination. Screen annually for lo extremity complication stratification.		

RAND

Worksheet 2A. ACTION PLAN FOR GUIDELINE INTRODUCTION AND STAFF EDUCATION

Identify action introduction and
Action #IN.__
Action #IN.__
Action #IN.__
Action #IN.__

RAND

Worksheet 3. GANTT CHART OF TIMELINE FOR GUIDELINE IMPLEMENTATION
Guideline: Management of Diabetes in Primary Care, March 2003 Update

Actions	MONTH OF WORK											
	1	2	3	4	5	6	7	8	9	10	11	12
Introduction & Education #IN.__ #IN.__ #IN.__ #IN.__												
Practice Changes #___ #___ #___ #___ #___ #___ #___ #___												

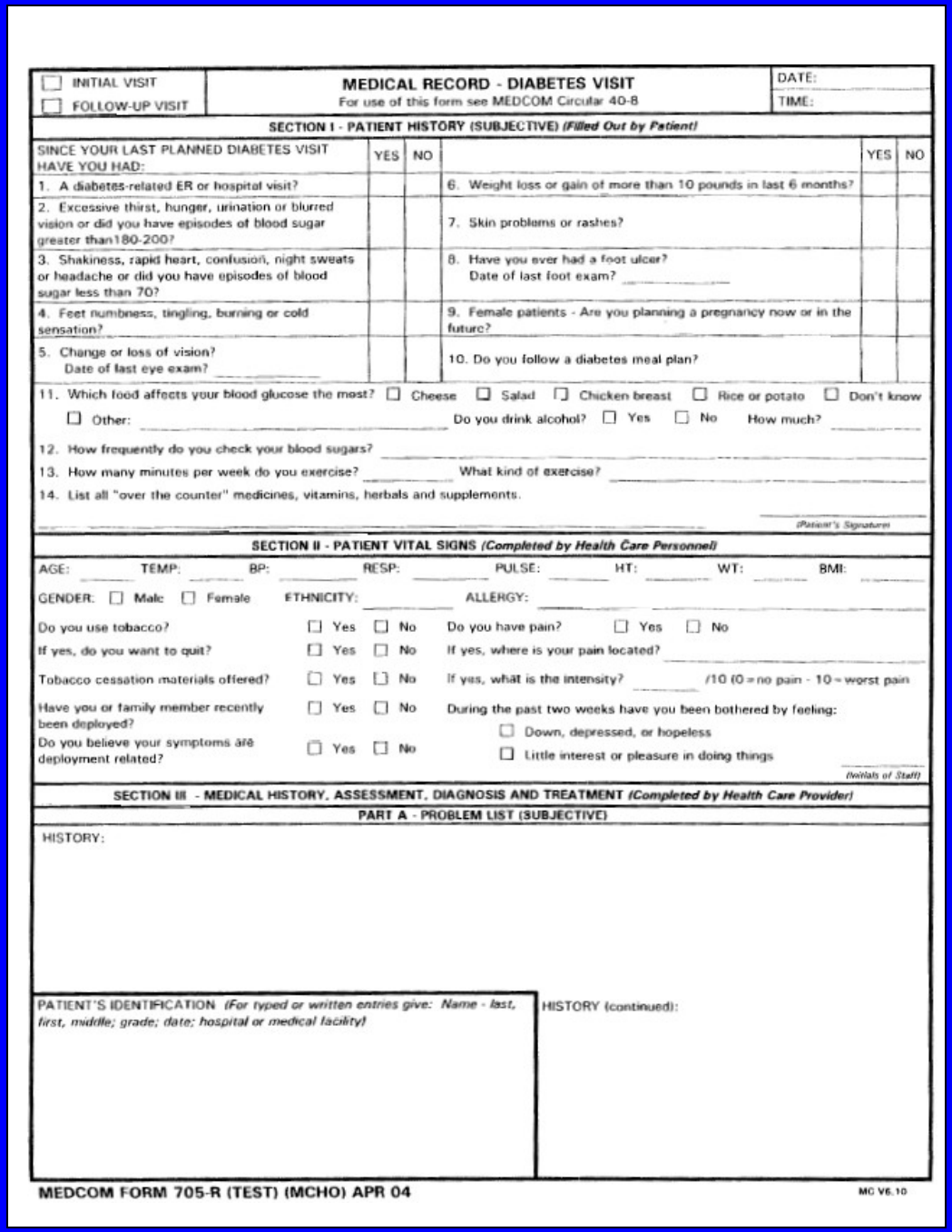
RAND

Provider Documentation Form

MEDCOM Test Form 705R

Front

Have patient fill out patient section, Section II 1-16, place in medical record for provider



☐ INITIAL VISIT
☐ FOLLOW-UP VISIT

MEDICAL RECORD - DIABETES VISIT
For use of this form see MEDCOM Circular 40-8

DATE:
TIME:

SECTION I - PATIENT HISTORY (SUBJECTIVE) *(Filled Out by Patient)*

SINCE YOUR LAST PLANNED DIABETES VISIT HAVE YOU HAD:	YES	NO		YES	NO
1. A diabetes-related ER or hospital visit?			6. Weight loss or gain of more than 10 pounds in last 6 months?		
2. Excessive thirst, hunger, urination or blurred vision or did you have episodes of blood sugar greater than180-200?			7. Skin problems or rashes?		
3. Shakiness, rapid heart, confusion, night sweats or headache or did you have episodes of blood sugar less than 70?			8. Have you ever had a foot ulcer? Date of last foot exam? _____		
4. Feet numbness, tingling, burning or cold sensation?			9. Female patients - Are you planning a pregnancy now or in the future?		
5. Change or loss of vision? Date of last eye exam? _____			10. Do you follow a diabetes meal plan?		

11. Which food affects your blood glucose the most? ☐ Cheese ☐ Salad ☐ Chicken breast ☐ Rice or potato ☐ Don't know
☐ Other: _____ Do you drink alcohol? ☐ Yes ☐ No How much? _____

12. How frequently do you check your blood sugars? _____

13. How many minutes per week do you exercise? _____ What kind of exercise? _____

14. List all "over the counter" medicines, vitamins, herbals and supplements.

_____ *(Patient's Signature)*

SECTION II - PATIENT VITAL SIGNS *(Completed by Health Care Personnel)*

AGE: _____ TEMP: _____ BP: _____ RESP: _____ PULSE: _____ HT: _____ WT: _____ BMI: _____

GENDER: ☐ Male ☐ Female ETHNICITY: _____ ALLERGY: _____

Do you use tobacco? ☐ Yes ☐ No
If yes, do you want to quit? ☐ Yes ☐ No
Tobacco cessation materials offered? ☐ Yes ☐ No
Have you or family member recently been deployed? ☐ Yes ☐ No
Do you believe your symptoms are deployment related? ☐ Yes ☐ No

Do you have pain? ☐ Yes ☐ No
If yes, where is your pain located? _____
If yes, what is the intensity? _____ /10 (0 = no pain - 10 = worst pain
During the past two weeks have you been bothered by feeling:
☐ Down, depressed, or hopeless
☐ Little interest or pleasure in doing things

(Initials of Staff)

SECTION III - MEDICAL HISTORY, ASSESSMENT, DIAGNOSIS AND TREATMENT *(Completed by Health Care Provider)*

PART A - PROBLEM LIST (SUBJECTIVE)

HISTORY:

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

HISTORY (continued):

MEDCOM FORM 705-R (TEST) (MCHO) APR 04

MC V6.10

Provider Documentation Form

MEDCOM Test Form 705R

Back

SECTION III - MEDICAL HISTORY, ASSESSMENT, DIAGNOSIS AND TREATMENT (Cont)

CAGE: ☐ Cut down ☐ Annoyed ☐ Guilty ☐ Eye opener

Medication list reviewed? ☐ Yes ☐ No

PART B - PHYSICAL EXAM (OBJECTIVE)

PHYSICAL EXAM *(Record significant findings below)*

HEENT: _____

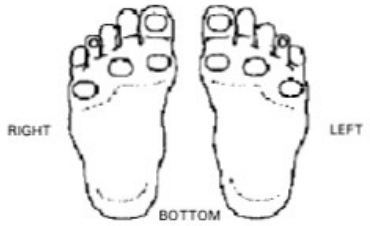
NECK: _____

CV: _____

LUNGS: _____

ABD: _____

EXTREMITIES: _____



FOOT EXAM:			NOT ASSESSED = NA
A. PEDAL PULSES	☐ YES	☐ NO	☐ NA
B. NAILS TOO THICK OR LONG	☐ YES	☐ NO	☐ NA
C. FOOT ABNORMAL SHAPE	☐ YES	☐ NO	☐ NA
D. VIBRATORY SENSE INTACT	☐ YES	☐ NO	☐ NA
E. EDEMA	☐ YES	☐ NO	☐ NA

DRAW/LABEL FINDINGS

C = Callous, U = Ulcer, M = Maceration, R = Redness, S = Swelling

MONOFILAMENT EXAM (Draw in circle):

+ = Positive sensation - = Negative sensation

OTHER:

PART C - DIAGNOSIS (ASSESSMENT)

☐ TYPE 1 DM ☐ TYPE 2 DM ☐ ADEQUATE CONTROL - NO CHANGE IN TREATMENT ☐ INADEQUATE CONTROL

WITH:

☐ DYSLIPIDEMIA	☐ NEUROPATHY	☐ CORONARY ARTERY DISEASE
☐ HYPERTENSION	☐ RETINOPATHY	☐ PERIPHERAL VASCULAR DISEASE
☐ NEPHROPATHY	☐ OBESITY	☐ PSYCHOSOCIAL
☐ OTHER: _____	☐ OTHER: _____	☐ OTHER: _____

PART D - TREATMENT PLAN

REMARKS:

☐ ASA 325 mg ☐ ANNUAL FLU VACCINE ☐ PNEUMONIA VACCINE ☐ ACE INHIBITOR *(Name & Dose)*: _____

LABS: ☐ A1C ☐ LIPIDS ☐ MICRO A/CR RATIO ☐ TSH ☐ CHEM 7 ☐ OTHER: _____

☐ DIABETIC ACTION PLAN REVIEWED AND GIVEN TO PATIENT

PART E - REFERRALS

☐ DM PATIENT EDUCATION	☐ NUTRITION THERAPY	☐ PHARMACY
☐ CASE MANAGEMENT	☐ OPHTHALMOLOGY/OPTOMETRY	☐ BEHAVORIAL HEALTH
☐ ENDOCRINOLOGY	☐ PODIATRY	☐ OTHER: _____
☐ NEPHROLOGY	☐ TOBACCO CESSATION PROGRAM	☐ OTHER: _____

PART F - FOLLOW-UP APPOINTMENT

☐ 1 MONTH ☐ 3 MONTHS ☐ 6 MONTHS ☐ 9 MONTHS ☐ OTHER: _____

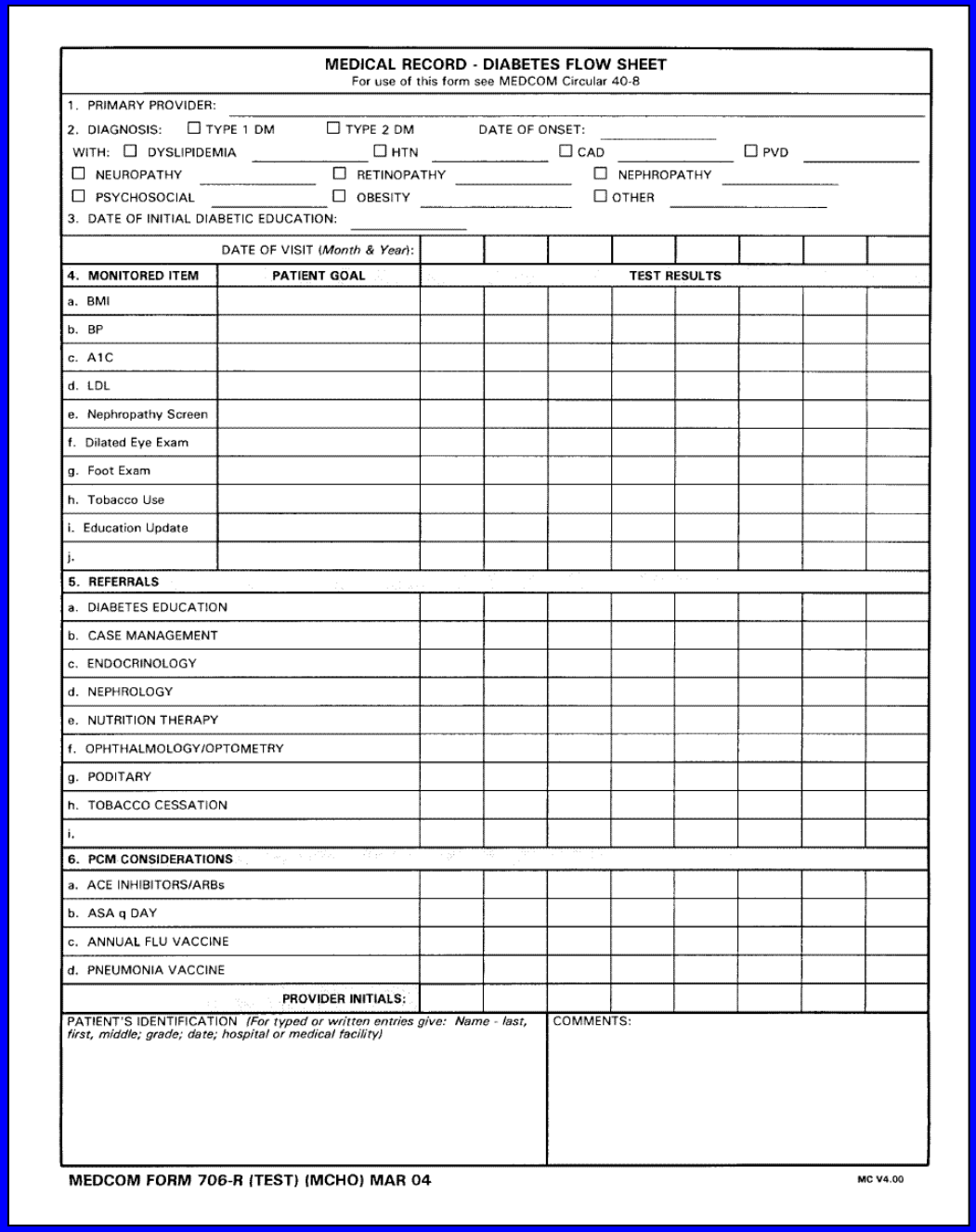
_____ _____

(Provider's Name) *(Provider's Signature)*

MEDCOM FORM 705-R (TEST) (MCHO) APR 04, Back

Provider Documentation Diabetes Flow Sheet

MEDCOM Test Form 706R



MEDICAL RECORD - DIABETES FLOW SHEET
For use of this form see MEDCOM Circular 40-8

1. PRIMARY PROVIDER: _____

2. DIAGNOSIS: ☐ TYPE 1 DM ☐ TYPE 2 DM DATE OF ONSET: _____

WITH: ☐ DYSLIPIDEMIA _____ ☐ HTN _____ ☐ CAD _____ ☐ PVD _____

☐ NEUROPATHY _____ ☐ RETINOPATHY _____ ☐ NEPHROPATHY _____

☐ PSYCHOSOCIAL _____ ☐ OBESITY _____ ☐ OTHER _____

3. DATE OF INITIAL DIABETIC EDUCATION: _____

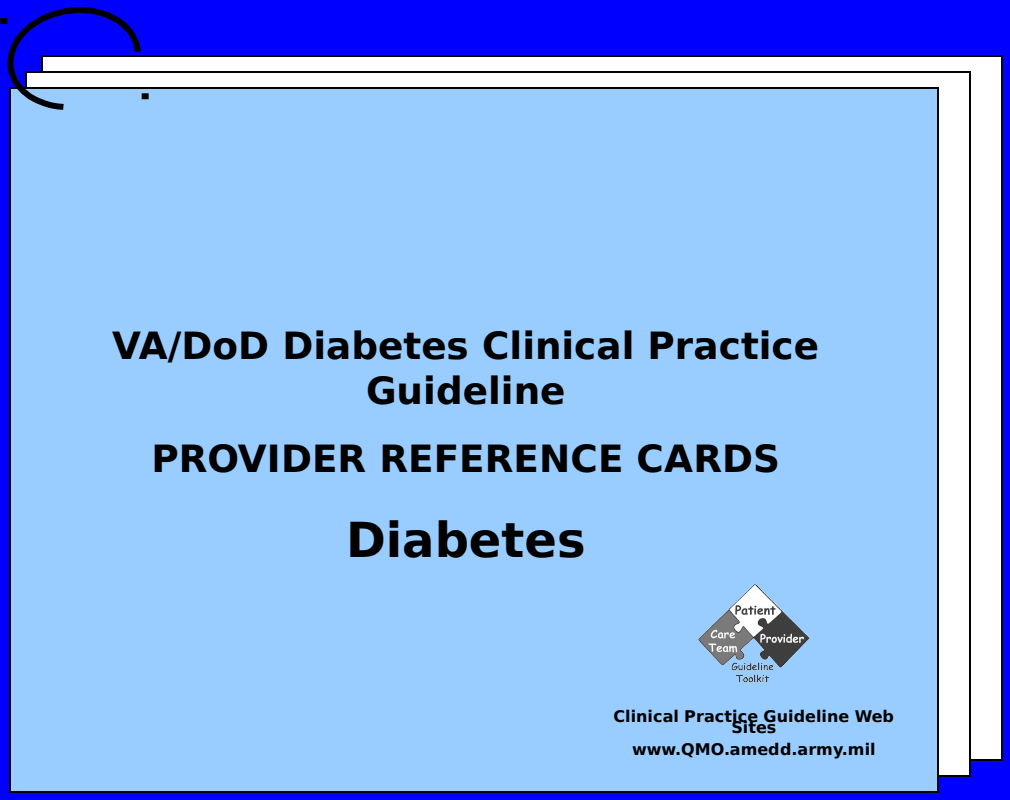
		DATE OF VISIT (*Month & Year*):							
4. MONITORED ITEM	**PATIENT GOAL**	**TEST RESULTS**							
a. BMI									
b. BP									
c. A1C									
d. LDL									
e. Nephropathy Screen									
f. Dilated Eye Exam									
g. Foot Exam									
h. Tobacco Use									
i. Education Update									
j.									
5. REFERRALS									
a. DIABETES EDUCATION									
b. CASE MANAGEMENT									
c. ENDOCRINOLOGY									
d. NEPHROLOGY									
e. NUTRITION THERAPY									
f. OPHTHALMOLOGY/OPTOMETRY									
g. PODITARY									
h. TOBACCO CESSATION									
i.									
6. PCM CONSIDERATIONS									
a. ACE INHIBITORS/ARBs									
b. ASA q DAY									
c. ANNUAL FLU VACCINE									
d. PNEUMONIA VACCINE									
PROVIDER INITIALS:									

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

COMMENTS:

MEDCOM FORM 706-R (TEST) (MCHO) MAR 04 MC V4.00

Provider Exam Room Cards



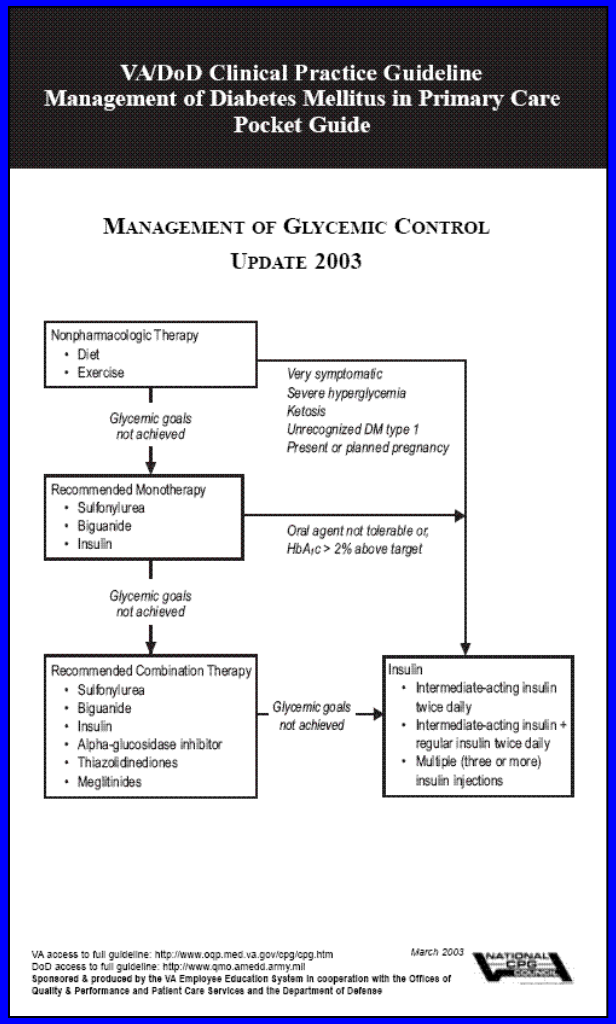
- Level "A" Recommendations
- Guideline Key Elements
- Determination of Target HBA1C Level
- Self-Management Principles and Process
- Oral Pharmacologic Agents
- Insulin
- Population Level Metrics

Diabetes Provider Pocket Cards

Management of Glycemic Control

and

Recommended Follow-up Pocket Cards



VA/DoD Clinical Practice Guideline
Management of Diabetes Mellitus in Primary Care
Pocket Guide

MANAGEMENT OF GLYCEMIC CONTROL
UPDATE 2003

Nonpharmacologic Therapy
- Diet
- Exercise

Glycemic goals not achieved

Recommended Monotherapy
- Sulfonylurea
- Biguanide
- Insulin

Glycemic goals not achieved

Recommended Combination Therapy
- Sulfonylurea
- Biguanide
- Insulin
- Alpha-glucosidase inhibitor
- Thiazolidinediones
- Meglitinides

Glycemic goals not achieved →

Insulin
- Intermediate-acting insulin twice daily
- Intermediate-acting insulin + regular insulin twice daily
- Multiple (three or more) insulin injections

Very symptomatic
Severe hyperglycemia
Ketosis
Unrecognized DM type 1
Present or planned pregnancy

Oral agent not tolerable or,
HbA_{1c} > 2% above target

VA access to full guideline: http://www.oqp.med.va.gov/cpg/cpg.htm
DoD access to full guideline: http://www.qmo.amedd.army.mil
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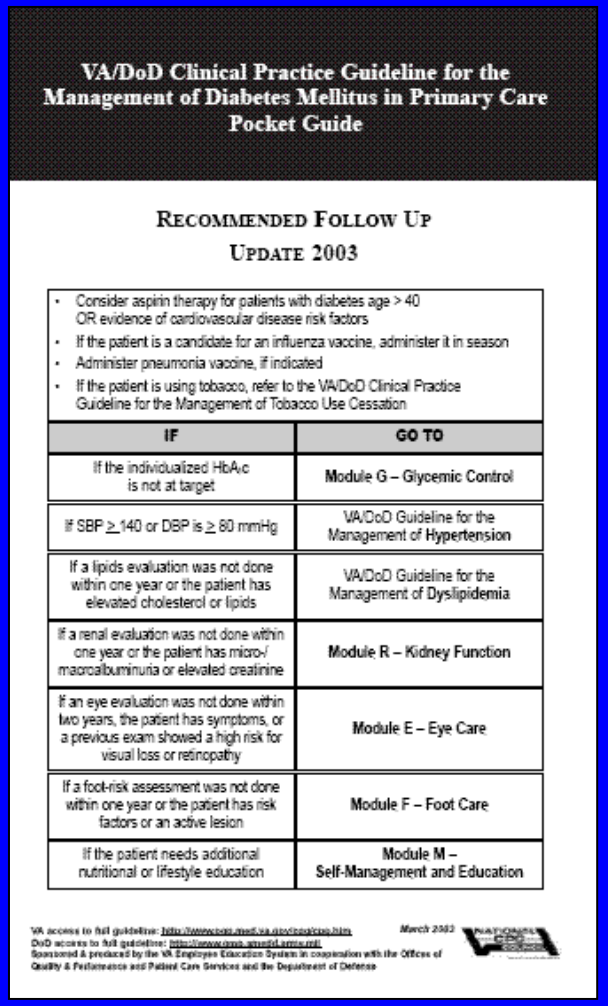
March 2003



VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus in Primary Care Pocket Guide

RECOMMENDED FOLLOW UP
UPDATE 2003

- Consider aspirin therapy for patients with diabetes age > 40 OR evidence of cardiovascular disease risk factors
- If the patient is a candidate for an influenza vaccine, administer it in season
- Administer pneumonia vaccine, if indicated
- If the patient is using tobacco, refer to the VA/DoD Clinical Practice Guideline for the Management of Tobacco Use Cessation

IF	GO TO
If the individualized HbA_{1c} is not at target	Module G – Glycemic Control
If SBP ≥ 140 or DBP is ≥ 80 mmHg	VA/DoD Guideline for the Management of Hypertension
If a lipids evaluation was not done within one year or the patient has elevated cholesterol or lipids	VA/DoD Guideline for the Management of Dyslipidemia
If a renal evaluation was not done within one year or the patient has micro-/ macroalbuminuria or elevated creatinine	Module R – Kidney Function
If an eye evaluation was not done within two years, the patient has symptoms, or a previous exam showed a high risk for visual loss or retinopathy	Module E – Eye Care
If a foot-risk assessment was not done within one year or the patient has risk factors or an active lesion	Module F – Foot Care
If the patient needs additional nutritional or lifestyle education	Module M – Self-Management and Education

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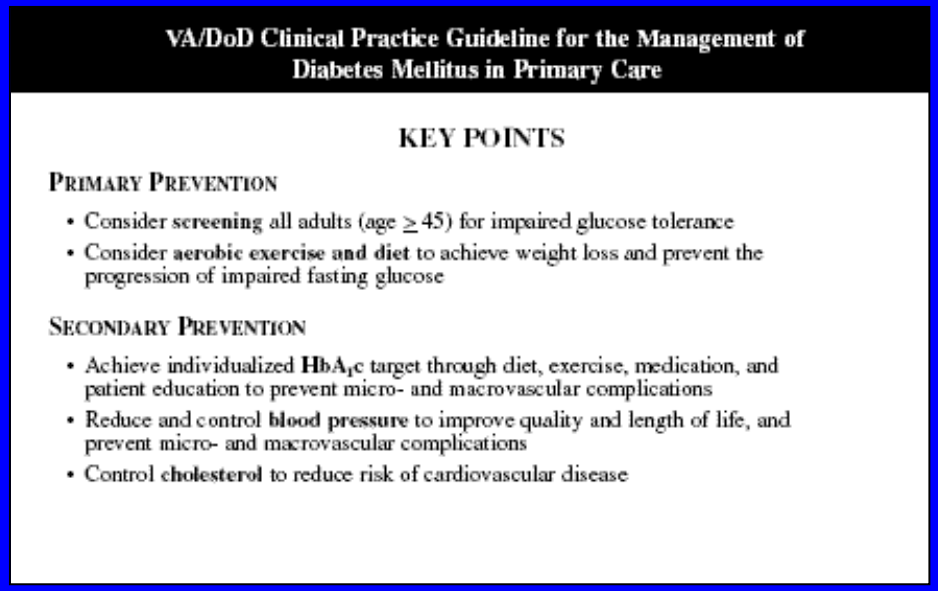
Diabetes Provider Key Points Card



VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus in Primary Care

KEY POINTS

PRIMARY PREVENTION

- Consider **screening** all adults (age ≥ 45) for impaired glucose tolerance
- Consider **aerobic exercise and diet** to achieve weight loss and prevent the progression of impaired fasting glucose

SECONDARY PREVENTION

- Achieve individualized **HbA_1c** target through diet, exercise, medication, and patient education to prevent micro- and macrovascular complications
- Reduce and control **blood pressure** to improve quality and length of life, and prevent micro- and macrovascular complications
- Control **cholesterol** to reduce risk of cardiovascular disease

Primary Prevention

Tertiary Prevention

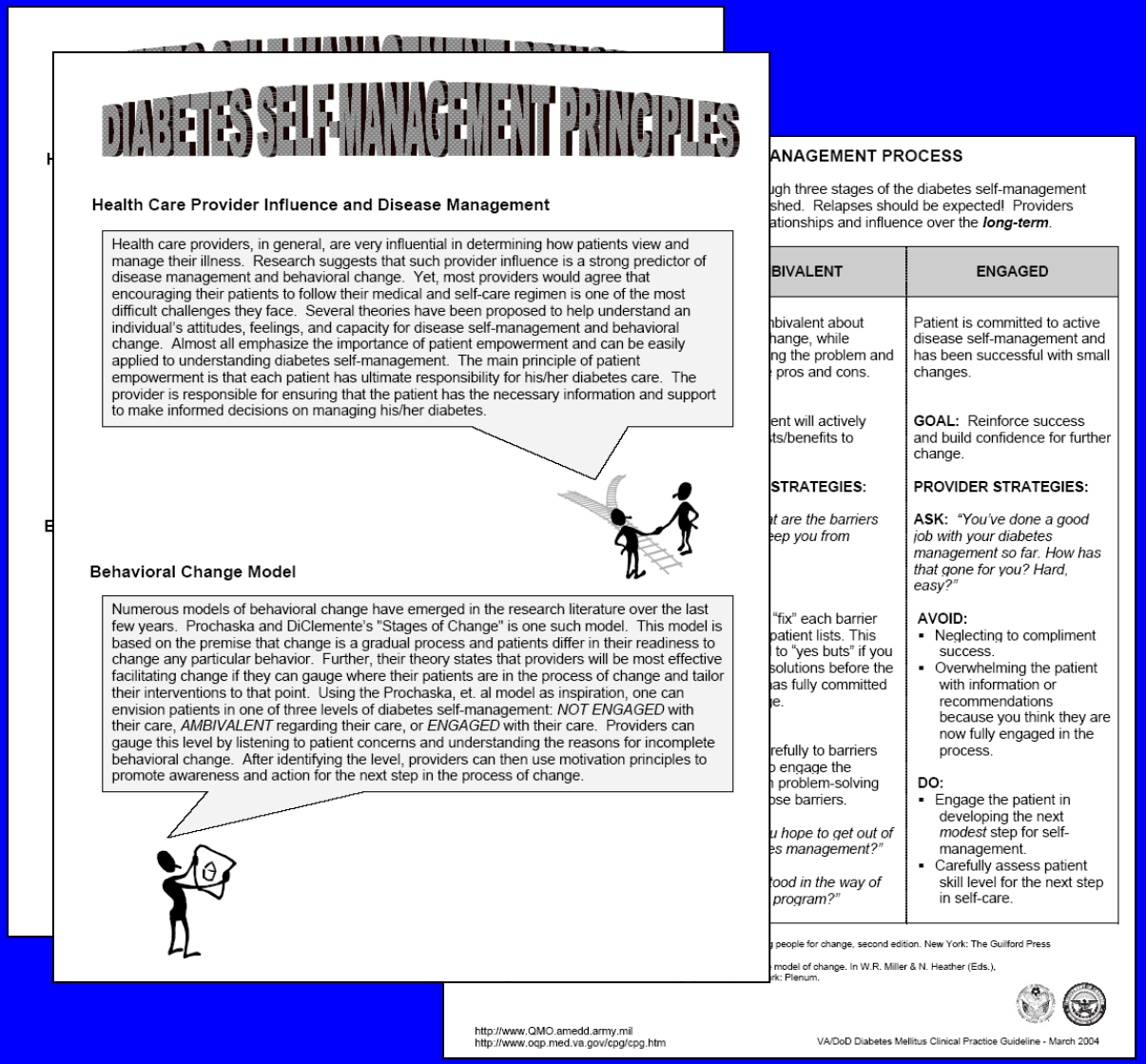
Secondary Prevention

Health Preventive Measures

Patient Education

Diabetes Self-Management Principles and Process

Motivational Tips for providers to assist patients with diabetes self-management



DIABETES SELF-MANAGEMENT PRINCIPLES

Health Care Provider Influence and Disease Management

Health care providers, in general, are very influential in determining how patients view and manage their illness. Research suggests that such provider influence is a strong predictor of disease management and behavioral change. Yet, most providers would agree that encouraging their patients to follow their medical and self-care regimen is one of the most difficult challenges they face. Several theories have been proposed to help understand an individual's attitudes, feelings, and capacity for disease self-management and behavioral change. Almost all emphasize the importance of patient empowerment and can be easily applied to understanding diabetes self-management. The main principle of patient empowerment is that each patient has ultimate responsibility for his/her diabetes care. The provider is responsible for ensuring that the patient has the necessary information and support to make informed decisions on managing his/her diabetes.

Behavioral Change Model

Numerous models of behavioral change have emerged in the research literature over the last few years. Prochaska and DiClemente's "Stages of Change" is one such model. This model is based on the premise that change is a gradual process and patients differ in their readiness to change any particular behavior. Further, their theory states that providers will be most effective facilitating change if they can gauge where their patients are in the process of change and tailor their interventions to that point. Using the Prochaska, et. al model as inspiration, one can envision patients in one of three levels of diabetes self-management: *NOT ENGAGED* with their care, *AMBIVALENT* regarding their care, or *ENGAGED* with their care. Providers can gauge this level by listening to patient concerns and understanding the reasons for incomplete behavioral change. After identifying the level, providers can then use motivation principles to promote awareness and action for the next step in the process of change.

ANAGEMENT PROCESS

ugh three stages of the diabetes self-management shed. Relapses should be expected! Providers ationships and influence over the ***long-term***.

BIVALENT	ENGAGED
bivalent about hange, while ng the problem and pros and cons.	Patient is committed to active disease self-management and has been successful with small changes.
ent will actively ts/benefits to	**GOAL:** Reinforce success and build confidence for further change.
STRATEGIES:	**PROVIDER STRATEGIES:**
t are the barriers eep you from	**ASK:** *"You've done a good job with your diabetes management so far. How has that gone for you? Hard, easy?"*
"fix" each barrier patient lists. This to "yes buts" if you solutions before the as fully committed e.	**AVOID:** ▪ Neglecting to compliment success. ▪ Overwhelming the patient with information or recommendations because you think they are now fully engaged in the process.
refully to barriers engage the problem-solving se barriers.	**DO:** ▪ Engage the patient in developing the next *modest* step for self-management. ▪ Carefully assess patient skill level for the next step in self-care.
u hope to get out of es management?"	
ood in the way of program?"	

people for change, second edition. New York: The Guilford Press

model of change. In W.R. Miller & N. Heather (Eds.), rk: Plenum.

http://www.QMO.amedd.army.mil
http://www.oqp.med.va.gov/cpg/cpg.htm

VA/DoD Diabetes Mellitus Clinical Practice Guideline - March 2004

VA Diabetes Self-Management Health Tips

Provider Office Tool to assist patients with diabetes self-management

DIABETES SELF-MANAGEMENT HEALTH TIPS

As you learn about your diagnosis of diabetes, please know that your healthcare team is committed to helping you enjoy many more years of healthy, active life. Diabetes is a chronic disease that is BEST MANAGED BY YOU, with support from your family, friends, and healthcare team. Research tells us that patients themselves are in the best position to know what they need to manage their health. There are 8,760 hours in a year, and only a handful of hours are spent with the healthcare team. So knowing what to do, and doing it, is essential to maintaining your health.

Most persons think of diabetes as a disease of high blood sugar, but for many persons it is associated with high blood pressure and high cholesterol. Controlling ALL of these factors is important to REDUCE the risk of developing the major complications of diabetes: blindness, foot disease, kidney failure, heart attack, and stroke. IN FACT, the major cause of disability and death in diabetes is heart disease and stroke. For many persons with diabetes, controlling blood pressure and cholesterol, taking aspirin, and NOT smoking are the most important steps that they can take.

SCREENING for complications is important to determine whether you already have eye, foot, or kidney disease. If you do, you may need to have more frequent follow-up visits, new, medications, or other treatments.

The following HEALTH TIPS SUMMARY is a guide to the essentials of diabetes care. Each person with diabetes is unique. We would like to help you develop the confidence and motivation to use your skills and knowledge to be the expert decision-maker in your diabetes management.

Protect yourself. Take responsibility for the following:

Smoking: If you smoke or use tobacco, **STOP!** Please talk to your healthcare team about what steps you can take. Benefits start immediately.

Influenza – in season: Get a YEARLY vaccination. Being vaccinated last year doesn't protect you this year. Getting a flu vaccination doesn't give you the flu.

Pneumococcal vaccination: Once in lifetime. However, if you were vaccinated more than 5 years ago, talk to your provider about whether you need a second one.

Aspirin: Aspirin decreases the risk of heart attacks for many persons—ask your health provider if there is a reason you should not take this medication.

Nutrition and Exercise: Following an appropriate diet and exercise are cornerstones of diabetes management. Work with your healthcare team to develop a plan that is right for you!

Medications: Carry a list of your current medications.

Access this document for downloading at
http://www.oqp.med.va.gov/cpg/DM/PI/DMHealthTips.pdf

Sponsored & produced by the VA Employee Education System in cooperation with the Offices of Quality & Performance and Patient Care Services and Department of Defense

NATIONAL CPG COUNCIL

…ur feet daily. Tell your health …ider about any changes. Have … health provider look at your …at each visit. Symptoms of pain …numbness in your feet are not …ys present, so ask your provider …e signs of blood vessel or nerve …eet. If you have blood vessel or …u are at higher risk for developing …itions and should be under the …cialist.

…n: Protein in urine is an early … disease. Know …e protein in your … serious kidney …ealth provider can …from a urine and …

… have protein in your urine, this …ne your A1c and Blood Pressure …, your health provider may want …n medications for you.

…gement: Common illnesses can …use problems for people with …abetes. When you are sick, …eck your blood sugar every few …urs. If your blood sugar remains …er 250 or is repeatedly below …, contact your healthcare team …ospital. Take your insulin or …ess you cannot take any food or …iquids every hour to avoid …

eye conditions such as glaucoma or cataracts.

VA and DoD Champion Briefs

VA/DoD Diabetes Mellitus CPG Update

Dr Len Pogach, VA Diabetes Champion
National Program Director, Diabetes
New Jersey VA Health Care System
East Orange, New Jersey

March 2004

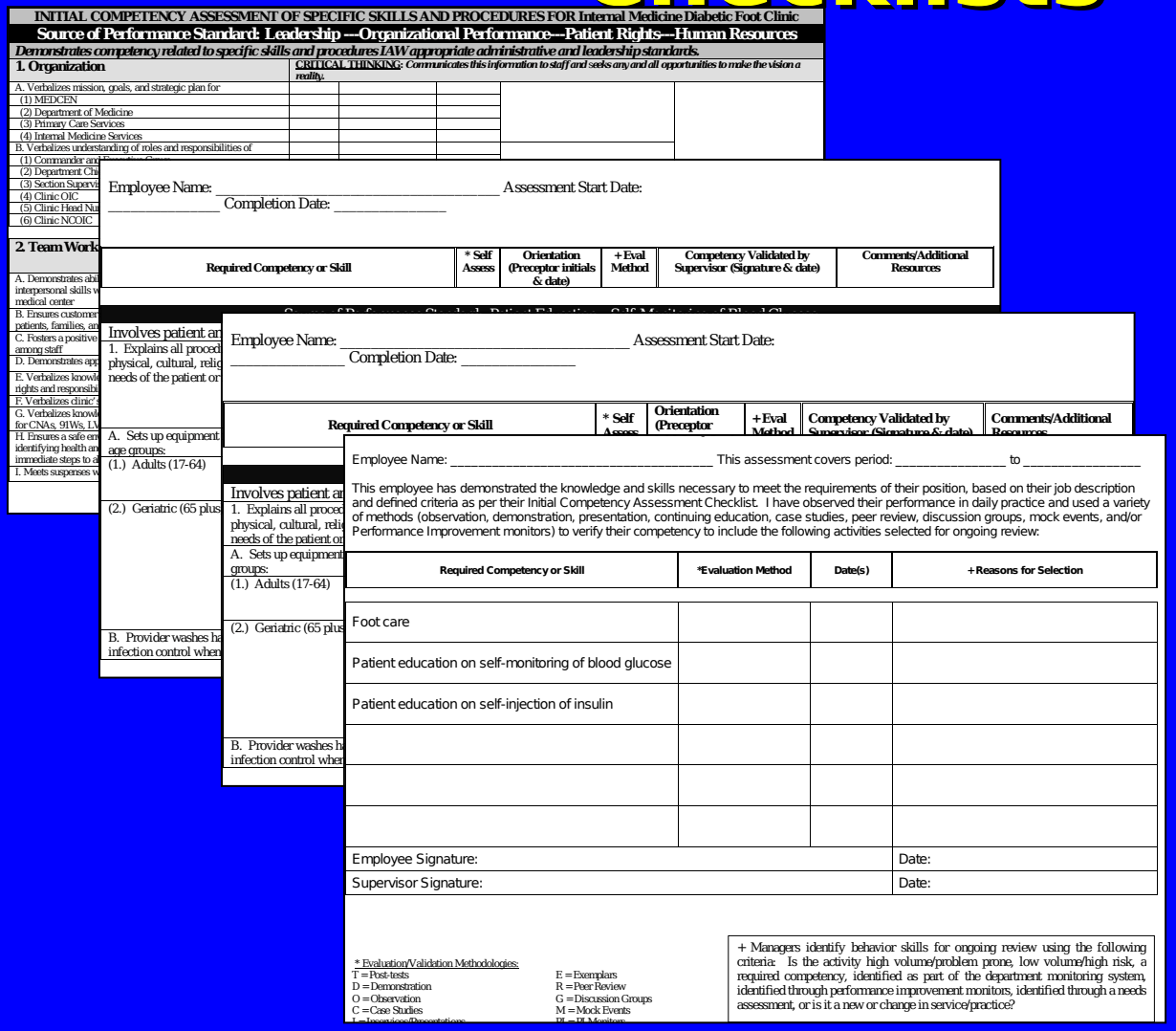
Key Elements and Changes

VA/DoD Diabetes Clinical Practice Guideline

Curtis Hobbs MD, COL MC
DoD Diabetes Mellitus Guideline Champion
Chief, Endocrine Service Madigan Army Medical Center
Consultant to OTSG for Endocrinology

March 2004

Competency Assessment Checklists


INITIAL COMPETENCY ASSESSMENT OF SPECIFIC SKILLS AND PROCEDURES FOR Internal Medicine Diabetic Foot Clinic

Source of Performance Standard: Leadership ---Organizational Performance---Patient Rights---Human Resources

Demonstrates competency related to specific skills and procedures IAW appropriate administrative and leadership standards.

1. Organization — CRITICAL THINKING: *Communicates this information to staff and seeks any and all opportunities to make the vision a reality.*

A. Verbalizes mission, goals, and strategic plan for
(1) MEDCEN
(2) Department of Medicine
(3) Primary Care Services
(4) Internal Medicine Services
B. Verbalizes understanding of roles and responsibilities of
(1) Commander and
(2) Department Cha
(3) Section Supervi
(4) Clinic OIC
(5) Clinic Head Nur
(6) Clinic NCOIC

2. Team Work

A. Demonstrates abil interpersonal skills w medical center
B. Ensures customer patients, families, an
C. Fosters a positive among staff
D. Demonstrates ap
E. Verbalizes knowle rights and responsibi
F. Verbalizes clinic'
G. Verbalizes knowle for CNAs, 91Ws, LV
H. Ensures a safe en identifying health an immediate steps to a
I. Meets suspenses w

Employee Name: _____ Assessment Start Date: _____ Completion Date: _____

Required Competency or Skill	* Self Assess	Orientation (Preceptor initials & date)	+ Eval Method	Competency Validated by Supervisor (Signature & date)	Comments/Additional Resources

Involves patient ar
1. Explains all proced physical, cultural, relig needs of the patient or

A. Sets up equipment age groups:
(1.) Adults (17-64)
(2.) Geriatric (65 plus

B. Provider washes ha infection control when

Employee Name: _____ Assessment Start Date: _____ Completion Date: _____

Required Competency or Skill	* Self Assess	Orientation (Preceptor	+ Eval Method	Competency Validated by Supervisor (Signature & date)	Comments/Additional Resources

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A. Sets up equipment groups:
(1.) Adults (17-64)
(2.) Geriatric (65 plus

B. Provider washes ha infection control when

Employee Name: _____ This assessment covers period: _____ to _____

This employee has demonstrated the knowledge and skills necessary to meet the requirements of their position, based on their job description and defined criteria as per their Initial Competency Assessment Checklist. I have observed their performance in daily practice and used a variety of methods (observation, demonstration, presentation, continuing education, case studies, peer review, discussion groups, mock events, and/or Performance Improvement monitors) to verify their competency to include the following activities selected for ongoing review:

Required Competency or Skill	*Evaluation Method	Date(s)	+Reasons for Selection
Foot care			
Patient education on self-monitoring of blood glucose			
Patient education on self-injection of insulin			
Employee Signature:			Date:
Supervisor Signature:			Date:

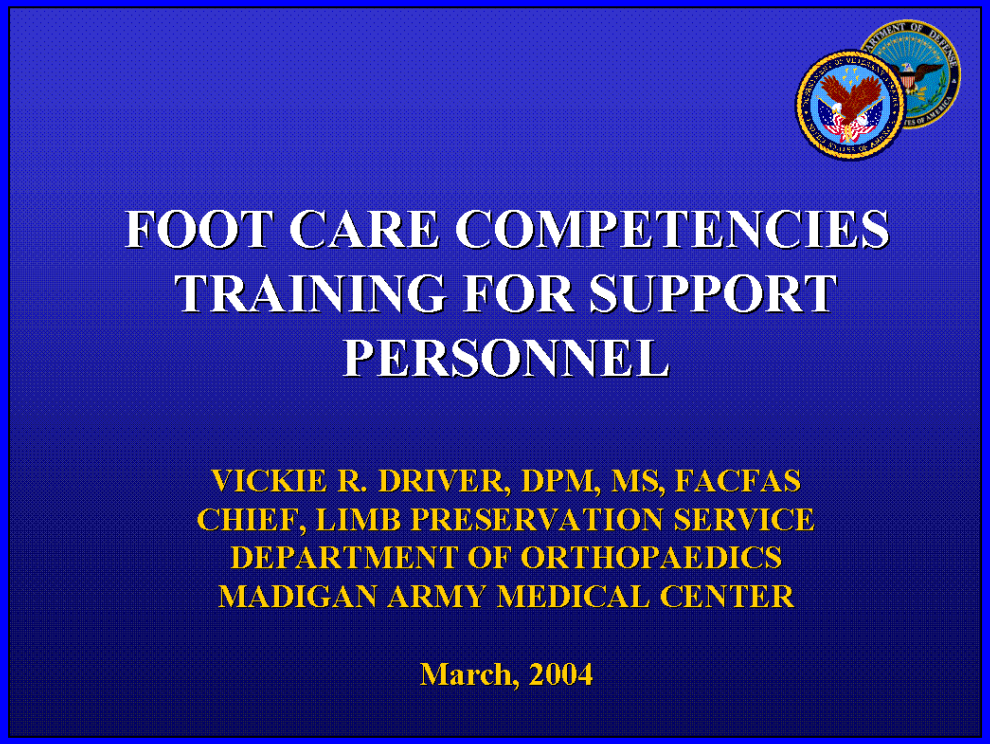
* Evaluation/Validation Methodologies:
T = Post-tests
D = Demonstration
O = Observation
C = Case Studies
E = Exemplars
R = Peer Review
G = Discussion Groups
M = Mock Events

+ Managers identify behavior skills for ongoing review using the following criteria: Is the activity high volume/problem prone, low volume/high risk, a required competency, identified as part of the department monitoring system, identified through performance improvement monitors, identified through a needs assessment, or is it a new or change in service/practice?

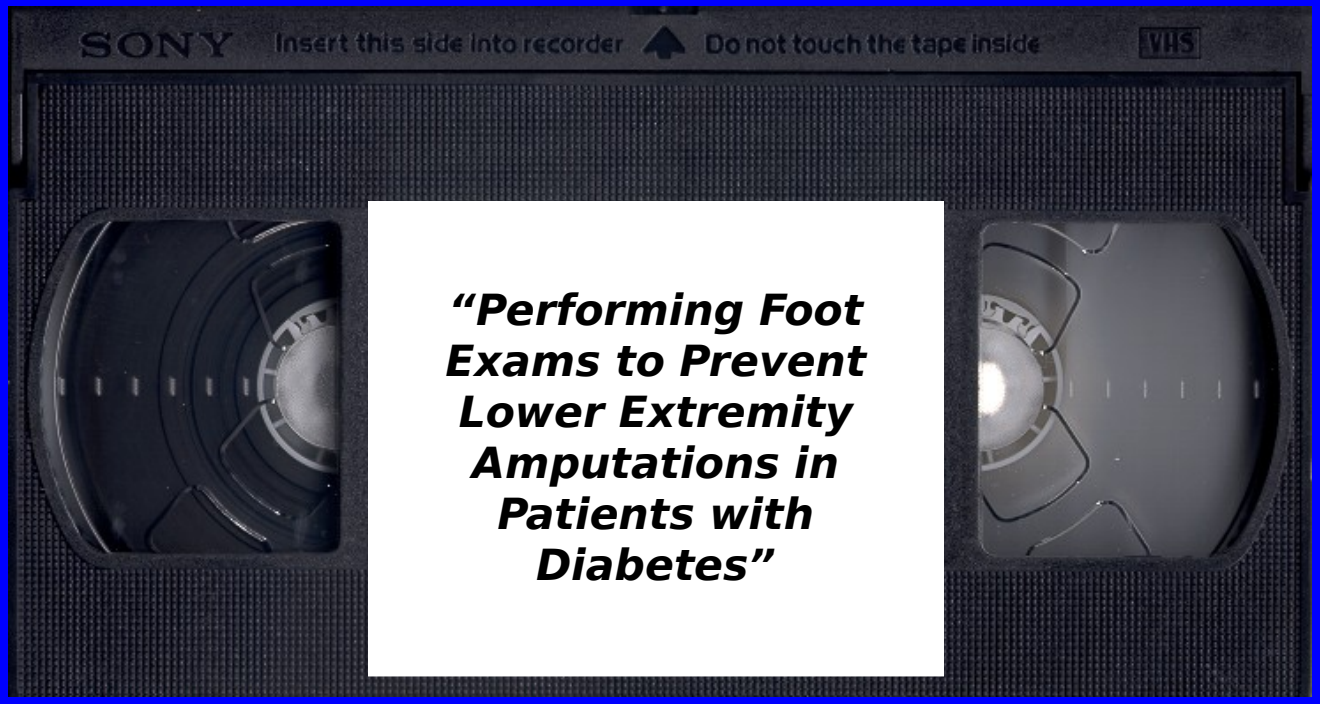
- Foot Care
- Blood Glucose Self-Monitoring
- Insulin Self-Injection
- On-going Competency

https://akm.amedd.army.mil/competency

Competency Assessment Training Brief



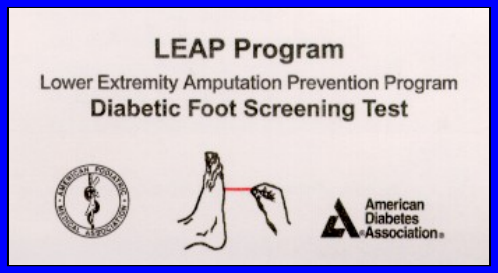
Diabetes Foot Video


SONY
Insert this side into recorder
Do not touch the tape inside
VHS
"Performing Foot Exams to Prevent Lower Extremity Amputations in Patients with Diabetes"

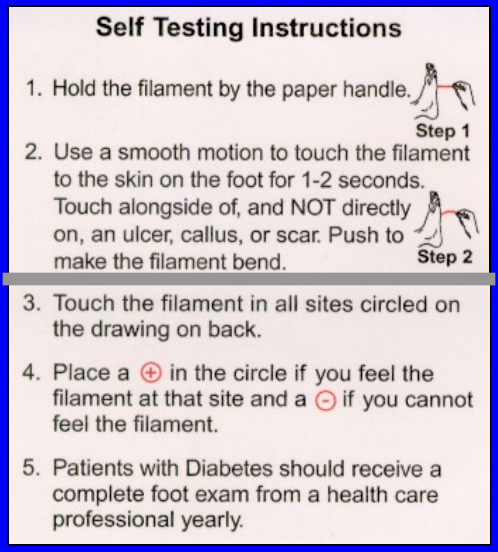
The diabetes CPG binder also has a Foot Care Competency SOP and checklist for training

Monofilament Card

Front Cover



Inside


Self Testing Instructions
1. Hold the filament by the paper handle.
Step 1
2. Use a smooth motion to touch the filament to the skin on the foot for 1-2 seconds. Touch alongside of, and NOT directly on, an ulcer, callus, or scar. Push to make the filament bend.
Step 2
3. Touch the filament in all sites circled on the drawing on back.
4. Place a ⊕ in the circle if you feel the filament at that site and a ⊖ if you cannot feel the filament.
5. Patients with Diabetes should receive a complete foot exam from a health care professional yearly.

Back Cover

Diabetic Foot Screen Test Sites
Right Foot
Left Foot
If you have a ⊖ in any circle, take this form to your health care provider as soon as possible.

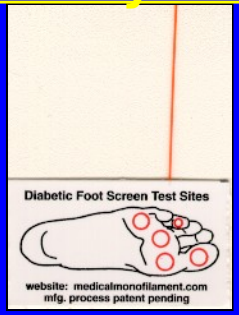
Monofilament Re-Order Information:

Leap Program:
http://bphc.hrsa.gov/leap/

National Diabetes Education Program:
http://www.ndep.nih.gov/diabetes/pubs/feet_broch_Eng.pdf

MEDCOM QM CPG Shopping Cart:
www.qmo.amedd.army.mil

Monofilament



Patient Self-Management Tools

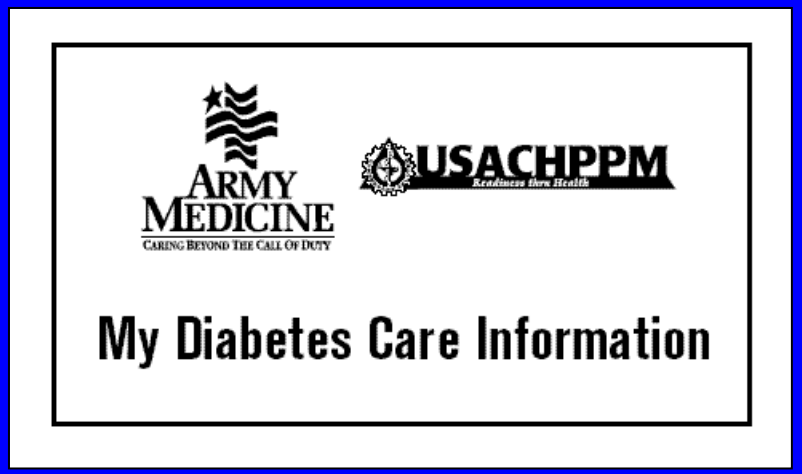
- **Patient outcomes (HgbA1c, BP, LDL) only improved if *patient-oriented* interventions were included.**
- **Self-management. . .**

  one size does NOT fit all

  - **Reminders**
  - **Education**
    - **Video, CD-ROM, Print, Web**
  - **Action Plans**

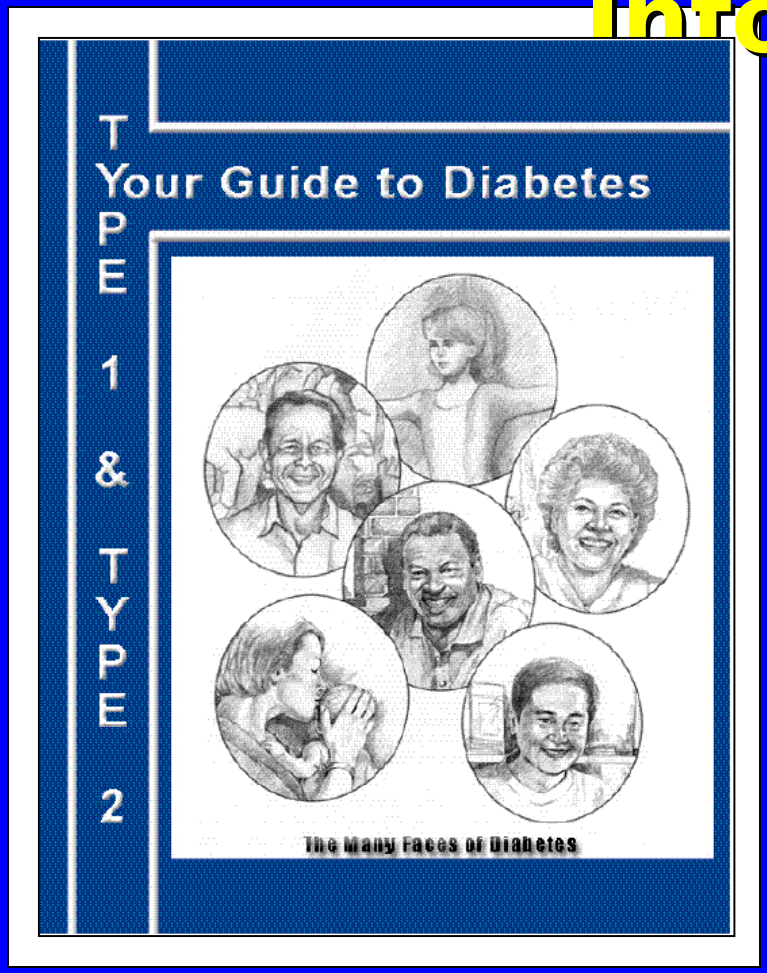
Patient Wallet Cards

Diabetes Emergency Treatment Card

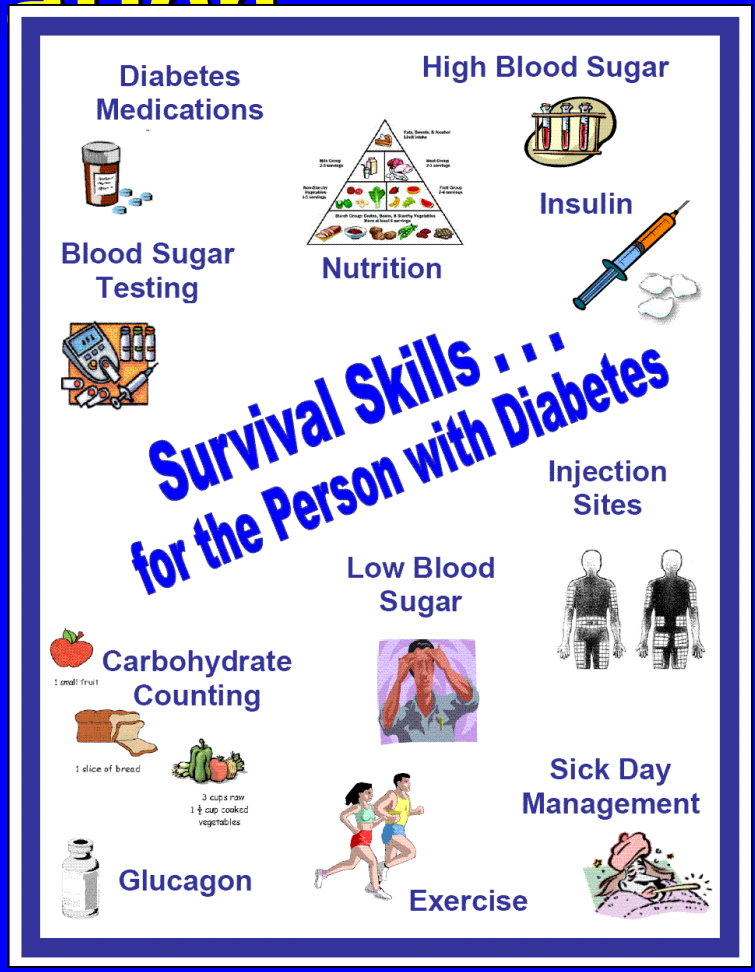


Diabetes Care Information Card

Diabetes Care Patient Information



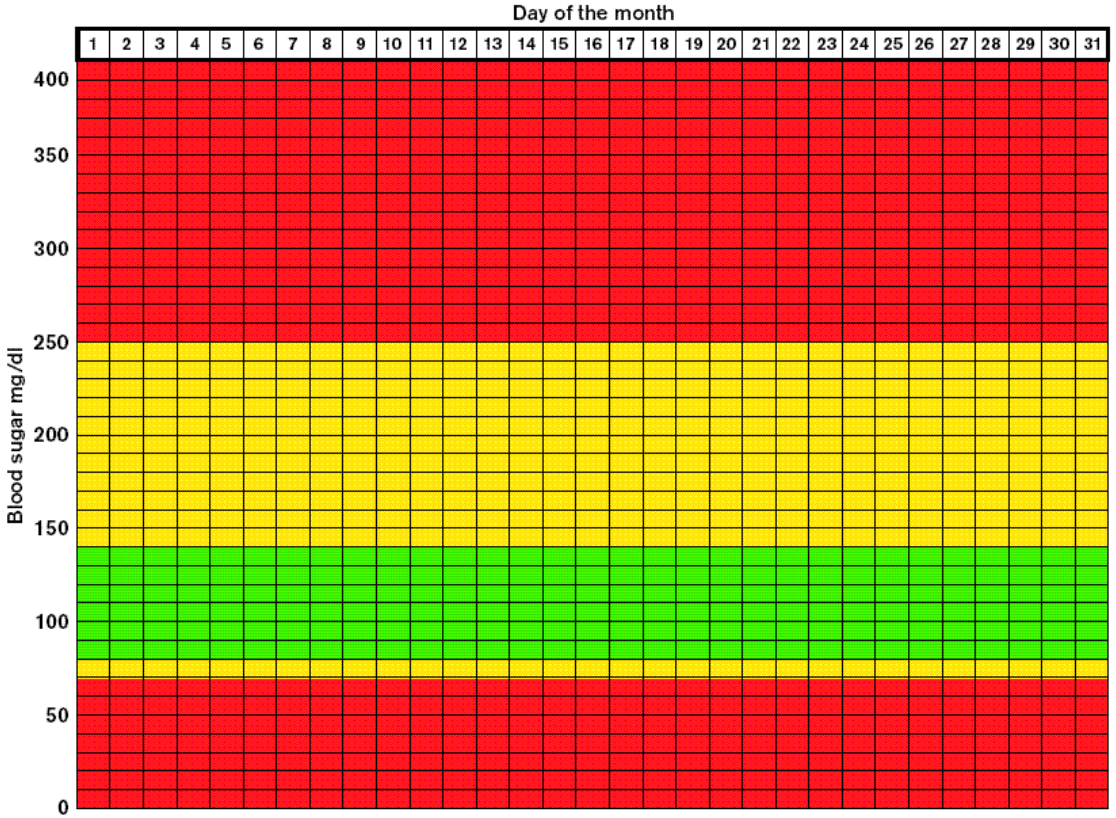
Your Guide To Diabetes Booklet: Type 1 and Type 2



Diabetes Survival Skills Handouts

Glucose Graph

My Blood Sugar Results for the Month of _____



Red, yellow and green zones are established by patient and provider.
Use "X" to mark your blood sugar level if tested before meals. Use "O" to mark your blood sugar level if tested after meals.

Fron

Blood Glucose Monitoring

I have discussed with my health care provider, why I should monitor my blood sugar and how often I should monitor the level. I realize that blood sugar changes throughout the day and is higher after eating and that monitoring my blood sugar will tell me how well my diabetes is controlled.

tivity I plan.
etermine if my diabetes medication is working

me.
are provider determine if my diet or medications

because my sugars are too high or too low.
the wrong direction. I should refer to my patient
els.

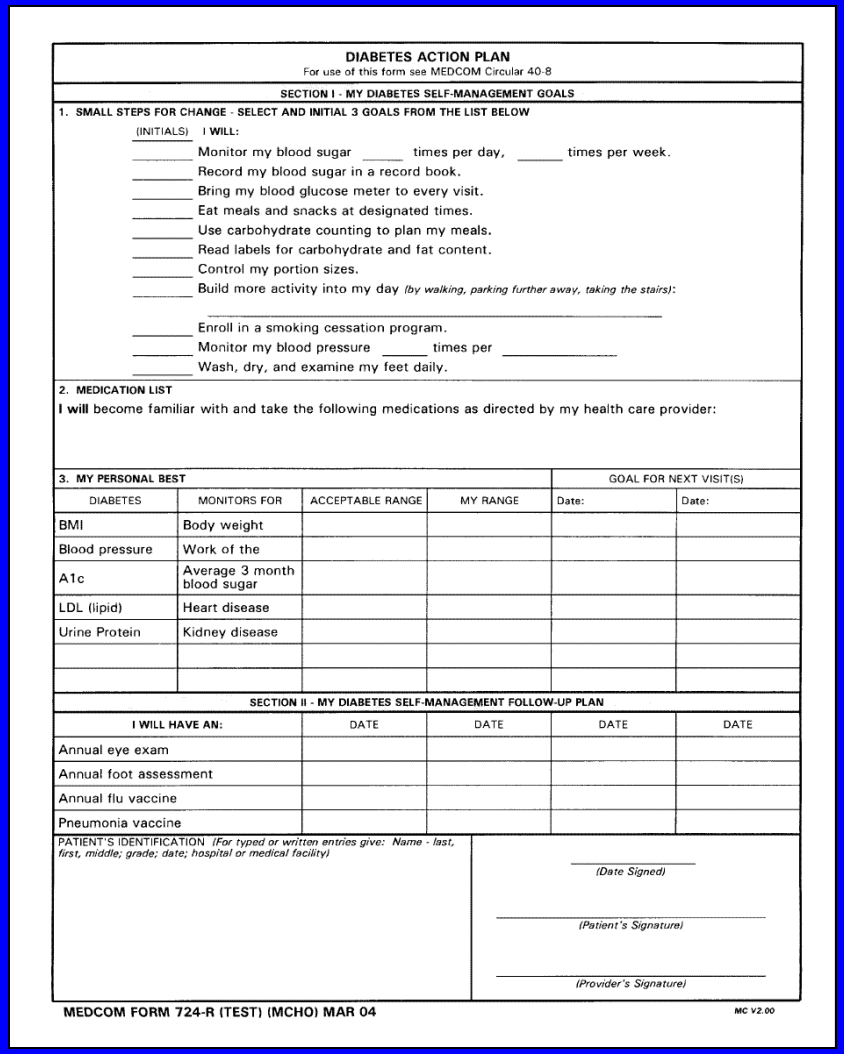
before/after meals, activity, at bedtime and

Signature: _____

VA/DoD Diabetes Mellitus Clinical Practice Guideline– November 2000

Back

Diabetes Action Plan



DIABETES ACTION PLAN
For use of this form see MEDCOM Circular 40-8

SECTION I - MY DIABETES SELF-MANAGEMENT GOALS

1. SMALL STEPS FOR CHANGE - SELECT AND INITIAL 3 GOALS FROM THE LIST BELOW

(INITIALS) **I WILL:**

_____ Monitor my blood sugar _____ times per day, _____ times per week.
_____ Record my blood sugar in a record book.
_____ Bring my blood glucose meter to every visit.
_____ Eat meals and snacks at designated times.
_____ Use carbohydrate counting to plan my meals.
_____ Read labels for carbohydrate and fat content.
_____ Control my portion sizes.
_____ Build more activity into my day *(by walking, parking further away, taking the stairs)*:
_____
_____ Enroll in a smoking cessation program.
_____ Monitor my blood pressure _____ times per _____
_____ Wash, dry, and examine my feet daily.

2. MEDICATION LIST

I will become familiar with and take the following medications as directed by my health care provider:

3. MY PERSONAL BEST

DIABETES	MONITORS FOR	ACCEPTABLE RANGE	MY RANGE	GOAL FOR NEXT VISIT(S) Date:	Date:
BMI	Body weight				
Blood pressure	Work of the				
A1c	Average 3 month blood sugar				
LDL (lipid)	Heart disease				
Urine Protein	Kidney disease				

SECTION II - MY DIABETES SELF-MANAGEMENT FOLLOW-UP PLAN

I WILL HAVE AN:	DATE	DATE	DATE	DATE
Annual eye exam				
Annual foot assessment				
Annual flu vaccine				
Pneumonia vaccine				

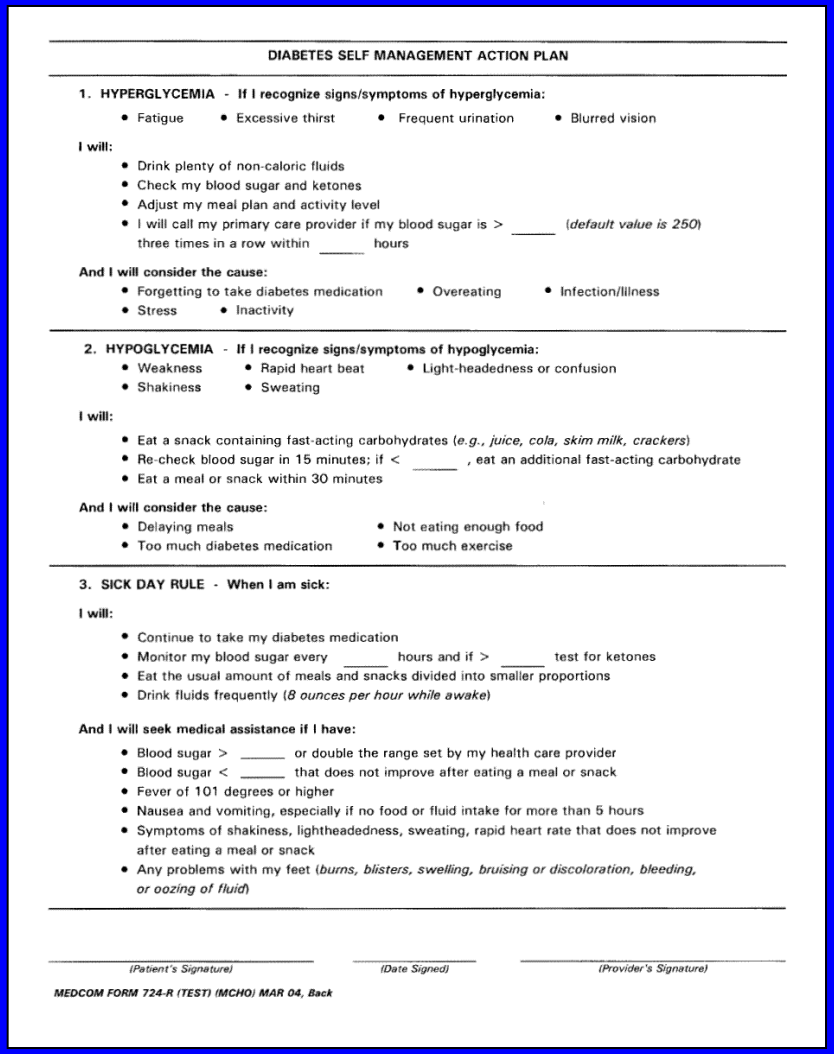
PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

_____ *(Date Signed)*

_____ *(Patient's Signature)*

_____ *(Provider's Signature)*

MEDCOM FORM 724-R (TEST) (MCHO) MAR 04 MC V2.00



DIABETES SELF MANAGEMENT ACTION PLAN

1. HYPERGLYCEMIA - If I recognize signs/symptoms of hyperglycemia:

- Fatigue
- Excessive thirst
- Frequent urination
- Blurred vision

I will:

- Drink plenty of non-caloric fluids
- Check my blood sugar and ketones
- Adjust my meal plan and activity level
- I will call my primary care provider if my blood sugar is > _____ *(default value is 250)* three times in a row within _____ hours

And I will consider the cause:

- Forgetting to take diabetes medication
- Overeating
- Infection/Illness
- Stress
- Inactivity

2. HYPOGLYCEMIA - If I recognize signs/symptoms of hypoglycemia:

- Weakness
- Rapid heart beat
- Light-headedness or confusion
- Shakiness
- Sweating

I will:

- Eat a snack containing fast-acting carbohydrates (*e.g., juice, cola, skim milk, crackers*)
- Re-check blood sugar in 15 minutes; if < _____ , eat an additional fast-acting carbohydrate
- Eat a meal or snack within 30 minutes

And I will consider the cause:

- Delaying meals
- Not eating enough food
- Too much diabetes medication
- Too much exercise

3. SICK DAY RULE - When I am sick:

I will:

- Continue to take my diabetes medication
- Monitor my blood sugar every _____ hours and if > _____ test for ketones
- Eat the usual amount of meals and snacks divided into smaller proportions
- Drink fluids frequently (*8 ounces per hour while awake*)

And I will seek medical assistance if I have:

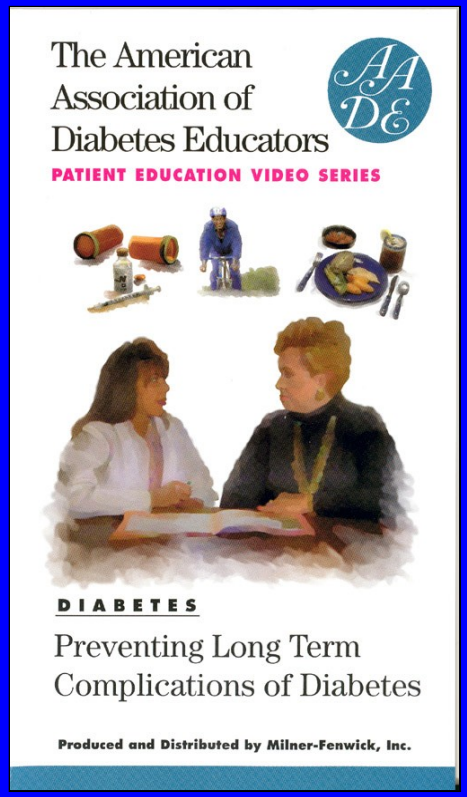
- Blood sugar > _____ or double the range set by my health care provider
- Blood sugar < _____ that does not improve after eating a meal or snack
- Fever of 101 degrees or higher
- Nausea and vomiting, especially if no food or fluid intake for more than 5 hours
- Symptoms of shakiness, lightheadedness, sweating, rapid heart rate that does not improve after eating a meal or snack
- Any problems with my feet (*burns, blisters, swelling, bruising or discoloration, bleeding, or oozing of fluid*)

_____ *(Patient's Signature)* _____ *(Date Signed)* _____ *(Provider's Signature)*

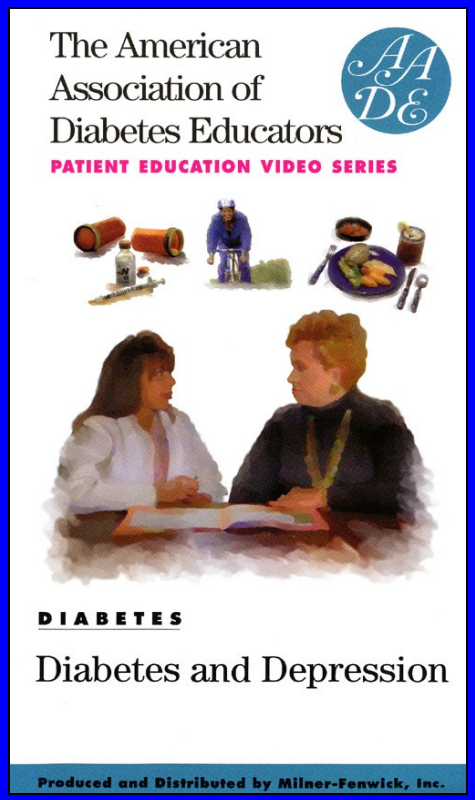
MEDCOM FORM 724-R (TEST) (MCHO) MAR 04, Back

Have patient complete the action plan and sign with the provider

American Association of Diabetes Educators Patient Videos


The American Association of Diabetes Educators
PATIENT EDUCATION VIDEO SERIES
DIABETES
Preventing Long Term Complications of Diabetes
Produced and Distributed by Milner-Fenwick, Inc.

Preventing Complications


The American Association of Diabetes Educators
PATIENT EDUCATION VIDEO SERIES
DIABETES
Diabetes and Depression
Produced and Distributed by Milner-Fenwick, Inc.

Diabetes and Depression

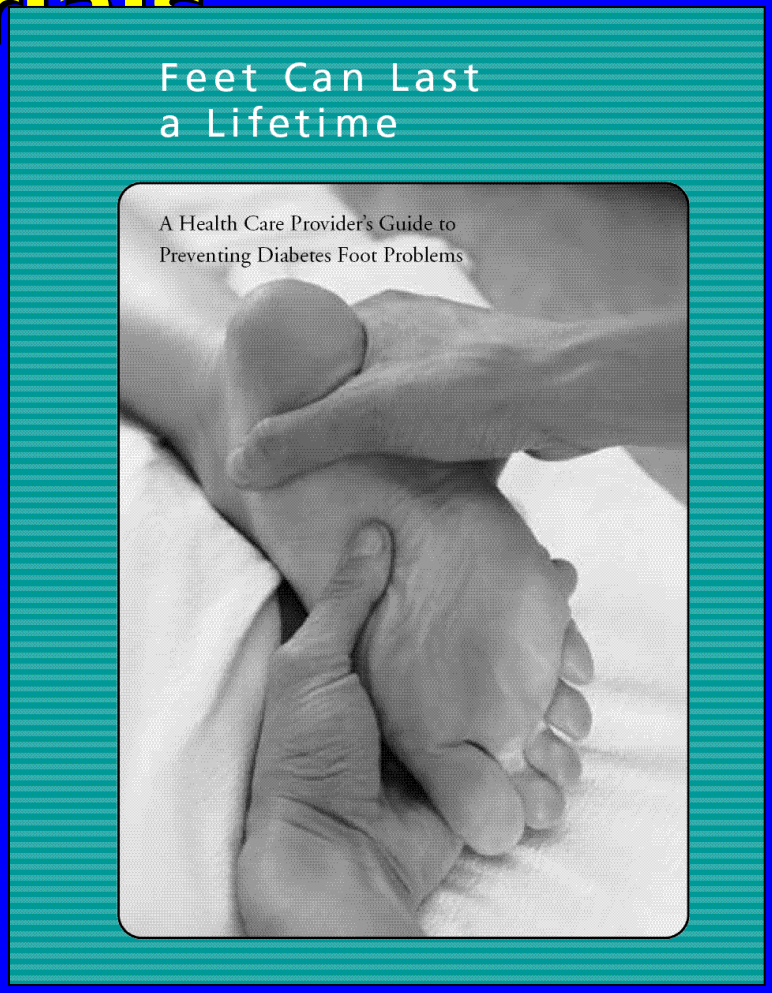
Available in complete DM toolkit

System Support Tools

- National Diabetes Education Program Materials
  - "Small Steps, Big Rewards: Your Game Plan for Preventing Type 2 Diabetes" Provider Toolkit and Patient booklet
  - "Feet Can Last a Lifetime"
- Posters
- ICD-9-CM Codes Specific for Diabetes
- Information Papers and AR 40-501
  - Diabetes Management and Deployment Issues, MRE Nutrition Fact Sheet, and Physical Profiles)
- Performance Metrics
- Website Information
- MHSPHP

National Diabetes Educational Program Materials

Small Steps. Big Rewards



Feet Can Last a Lifetime

Diabetes Foot Poster

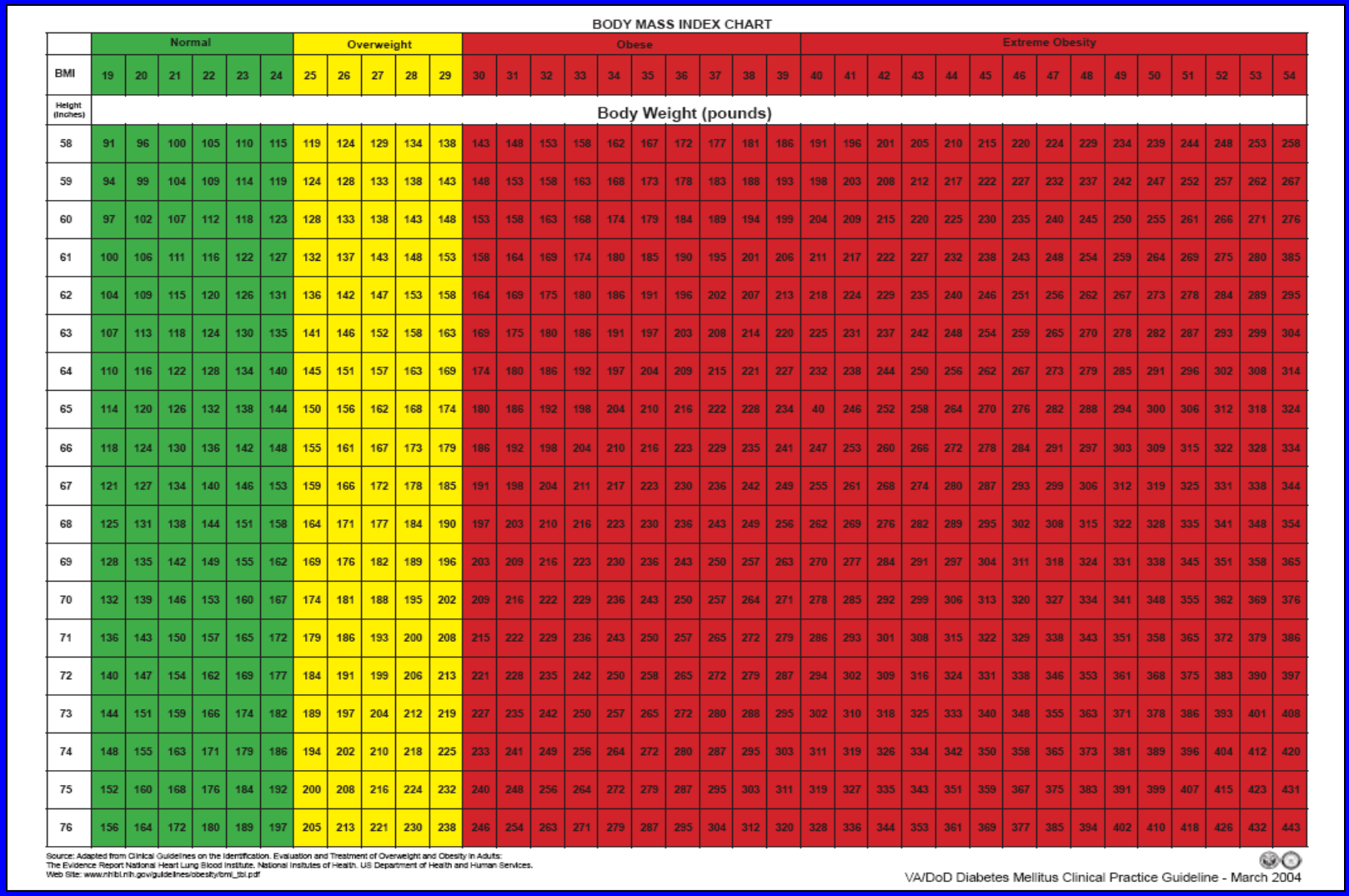
Take off your shoes and socks

Written in multiple languages

Hang in exam rooms

If you have diabetes,
please take off your shoes and socks.
Wenn Sie Diabetes haben, ziehen Sie bitte Ihre Schuhe und Socken aus.
Se soffrite di diabete, siete pregati di togliervi le scarpe e le calze.
Si usted tiene diabetes, por favor quítese las medias y los zapatos.
Kung mayroon kang diabetes, maari lang tanggalin ang sapatos at medyas.
Afai e maua oe i le mai suka, faamolemole aveese ou seevae ma totigi.
당뇨병이 있으신 분은 신발과 양말을 벗으십시오.
糖尿病の人は靴とソックスを脱いでください。

Body Mass Index Chart Poster



BODY MASS INDEX CHART

	Normal						Overweight					Obese										Extreme Obesity															
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (Inches)	Body Weight (pounds)																																			
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	385
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	40	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	432	443

Source: Adapted from Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults:
The Evidence Report National Heart Lung Blood Institute. National Institutes of Health. US Department of Health and Human Services.
Web Site: www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.pdf

VA/DoD Diabetes Mellitus Clinical Practice Guideline - March 2004

Tell Your Provider Poster

If You have **DIABETES**,

When was your last:

✓ **A1C?**

✓ **Blood Pressure Check?**

✓ **Cholesterol Check?**

✓ **Diabetes Eye Exam?**

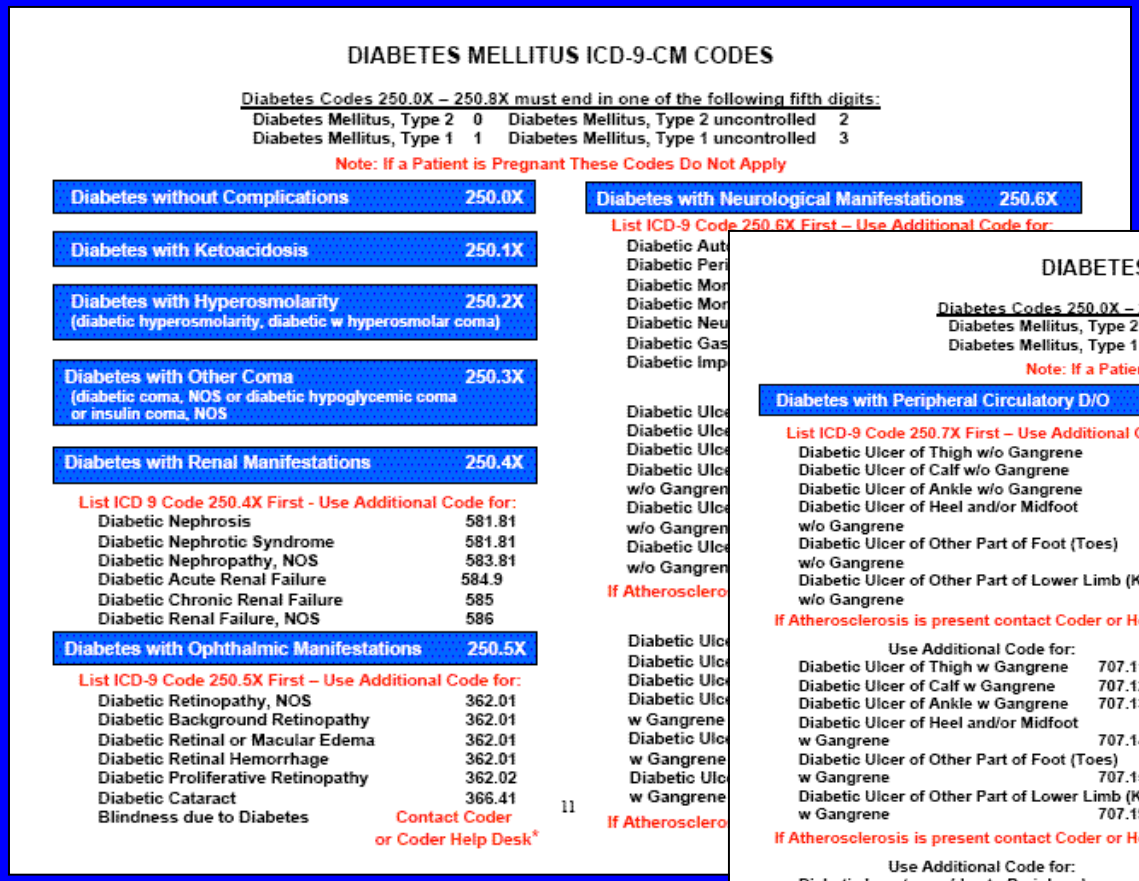
✓ **Diabetes Foot Exam?**

✓ **Urine Check for Protein?**

If you have not been checked in the last year, please tell your Provider.

VA/DoD Diabetes Mellitus Clinical Practice Guideline - March 2004

Diabetes ICD-9-CM Cards



DIABETES MELLITUS ICD-9-CM CODES

Diabetes Codes 250.0X – 250.8X must end in one of the following fifth digits:

Diabetes Mellitus, Type 2	0	Diabetes Mellitus, Type 2 uncontrolled	2
Diabetes Mellitus, Type 1	1	Diabetes Mellitus, Type 1 uncontrolled	3

Note: If a Patient is Pregnant These Codes Do Not Apply

Diabetes without Complications 250.0X

Diabetes with Ketoacidosis 250.1X

Diabetes with Hyperosmolarity 250.2X
(diabetic hyperosmolarity, diabetic w hyperosmolar coma)

Diabetes with Other Coma 250.3X
(diabetic coma, NOS or diabetic hypoglycemic coma or insulin coma, NOS

Diabetes with Renal Manifestations 250.4X

List ICD 9 Code 250.4X First - Use Additional Code for:

Diabetic Nephrosis	581.81
Diabetic Nephrotic Syndrome	581.81
Diabetic Nephropathy, NOS	583.81
Diabetic Acute Renal Failure	584.9
Diabetic Chronic Renal Failure	585
Diabetic Renal Failure, NOS	586

Diabetes with Ophthalmic Manifestations 250.5X

List ICD-9 Code 250.5X First – Use Additional Code for:

Diabetic Retinopathy, NOS	362.01
Diabetic Background Retinopathy	362.01
Diabetic Retinal or Macular Edema	362.01
Diabetic Retinal Hemorrhage	362.01
Diabetic Proliferative Retinopathy	362.02
Diabetic Cataract	366.41
Blindness due to Diabetes	Contact Coder or Coder Help Desk*

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Diabetes with Neurological Manifestations 250.6X

List ICD-9 Code 250.6X First – Use Additional Code for:

Diabetic Aut
Diabetic Peri
Diabetic Mor
Diabetic Mor
Diabetic Neu
Diabetic Gas
Diabetic Imp

Diabetic Ulce
Diabetic Ulce
Diabetic Ulce
Diabetic Ulce
w/o Gangren
Diabetic Ulce
w/o Gangren
Diabetic Ulce
w/o Gangren

If Atherosclero

Diabetic Ulc
Diabetic Ulc
Diabetic Ulc
Diabetic Ulc
w Gangrene
Diabetic Ulc
w Gangrene
Diabetic Ulc
w Gangrene

If Atherosclero

DIABETES MELLITUS ICD-9 CM CODES (continued)

Diabetes Codes 250.0X – 250.8X must end in one of the following fifth digits:

Diabetes Mellitus, Type 2	0	Diabetes Mellitus, Type 2 uncontrolled	2
Diabetes Mellitus, Type 1	1	Diabetes Mellitus, Type 1 uncontrolled	3

Note: If a Patient is Pregnant These Codes Do Not Apply

Diabetes with Peripheral Circulatory D/O 250.7X

List ICD-9 Code 250.7X First – Use Additional Code for:

Diabetic Ulcer of Thigh w/o Gangrene	707.11
Diabetic Ulcer of Calf w/o Gangrene	707.12
Diabetic Ulcer of Ankle w/o Gangrene	707.13
Diabetic Ulcer of Heel and/or Midfoot w/o Gangrene	707.14
Diabetic Ulcer of Other Part of Foot (Toes) w/o Gangrene	707.15
Diabetic Ulcer of Other Part of Lower Limb (Knee) w/o Gangrene	707.19

If Atherosclerosis is present contact Coder or Help Desk*

Use Additional Code for:

Diabetic Ulcer of Thigh w Gangrene	707.11 & 785.4
Diabetic Ulcer of Calf w Gangrene	707.12 & 785.4
Diabetic Ulcer of Ankle w Gangrene	707.13 & 785.4
Diabetic Ulcer of Heel and/or Midfoot w Gangrene	707.14 & 785.4
Diabetic Ulcer of Other Part of Foot (Toes) w Gangrene	707.15 & 785.4
Diabetic Ulcer of Other Part of Lower Limb (Knee) w Gangrene	707.19 & 785.4

If Atherosclerosis is present contact Coder or Help Desk*

Use Additional Code for:

Diabetic Impotence (due to Peripheral Circulatory Disorder)	607.84

* Coding Help Desk: www.pasba.amedd.army.mil
Click on "Data Coding"

Source: Physician ICD-9-CM, 2004, Volume 1 and 2, Medicode and Current Procedural Terminology (CPT) 2004, American Medical Association.

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Diabetes with Other Specified Manifestations 250.8X

List ICD-9 Code 250.8X First - Use Additional Code for:

Diabetic Ulcer of Thigh w/o Gangrene	707.11
Diabetic Ulcer of Calf w/o Gangrene	707.12
Diabetic Ulcer of Ankle w/o Gangrene	707.13
Diabetic Ulcer of Heel and/or Midfoot w/o Gangrene	707.14
Diabetic Ulcer of Other Part of Foot (Toes) w/o Gangrene	707.15
Diabetic Ulcer of Knee w/o Gangrene	707.19

If Atherosclerosis is present contact Coder or Help Desk*

Diabetic Hyperlipidemia	272.4
Diabetic Impotence (NOT due to Peripheral Circulatory or Neurological Disorder)	607.84

Other Associated Codes

Physician Educational Services Rendered to Patients in a Group Setting	CPT Code 99078
Nurse Visit – Office or Outpt	CPT Code 99211
Diabetic Mgt Program, Group Session	HCPCS Level II Code – S9455
Diabetic Mgt Program, Nurse Visit	HCPCS Level II Code – S9460
Diabetic Mgt Program, F/U Visit to Non-MD Provider	HCPCS Level II Code – S9140
Diabetic Mgt Program, F/U Visit to MD Provider	HCPCS Level II Code – S9141

VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus in Primary Care - March 2004

Front of Card

Back of Card

DM Management/Deployment Issues and MRE Fact Sheet

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

REPLY TO ATTENTION OF

DASG-HS-AS

31 Mar 2004

MEMORANDUM FOR REGIONAL MEDICAL COMMANDS

SUBJECT: Management and Deployment Issues Involving Soldiers with Diabetes

1. The purpose of this memorandum is to provide guidance on managing diabetic Soldiers in terms of: Referral to a Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB); physical profile criteria; and factors to be considered in rendering recommendations for or against deployment.

2. In accordance with AR 40-501, paragraph 3-11, Soldiers on active duty with diabetes who require insulin or oral medication(s) for control do not meet medical retention standards. They must be referred to an MEB and PEB for a fitness for duty determination.

3. In accordance with paragraph 9-10, AR 40-501, Reserve Component Soldiers not on active duty who do not meet medical retention standards (including those with diabetes) are transferred to the retired reserve unless they obtain a waiver to continue in the Reserves or unless a non-duty-related PEB finds them fit for duty.

4. Diabetes is a progressive disease. The Soldier with "diet-controlled" diabetes today will require oral medication(s) in the not-too-distant future. Eventually oral agents will also fail and insulin will be required. However, a Soldier with diabetes need not be referred to a PEB until he/she requires medication(s) to normalize his/her hemoglobin A1c. The number in the profile is not the determinant for referring a Soldier to a PEB. Soldiers with diabetes who require medication to achieve their target hemoglobin A1c must be referred to a PEB regardless of whether the Soldier has a P2 or P3 profile.

5. Profiles: A P2 profile may be appropriate for the lifestyle- or medically-managed Soldier with type 2 diabetes who has had no episodes of nor is at substantial risk for hypoglycemia, has a normal HbA1c, and is physically fit. Soldiers not meeting such requirements should be issued a P3 profile.

6. A number of factors should be considered before determining whether deployment, to certain locations, of a Soldier with diabetes is medically contraindicated. These

Meals Ready to Eat Nutrition Fact Sheet

INCREASED NEEDS DURING FIELD TRAINING:

- Most soldiers' nutrition needs are increased during a deployment due to increased activity during work (Ie: setting up tents), carrying extra equipment and temperature changes.
- Eating (at least) three meals per day will supply you adequate energy (Table 2)
- Proper hydration is also important, as temperatures and work load increase so do fluid needs. (Table 1)

HYDRATION:

Symptoms of dehydration: fatigue, confusion, headache, lightheadedness, dry mouth, decreased appetite, dark urine, infrequent urination

TABLE 1: BASIC FLUID NEEDS BASED ON ACTIVITY LEVEL (FM 21-10)

Heat Category	WBGT Index Degrees F	Easy Work* Water Intake Qt/hr	Moderate Work** Water Intake Qt/hr	Hard Work*** Water Intake Qt/hr
1	78 – 81.9	½	¾	¾
2 (Green)	82 – 84.9	½	¾	1
3 (Yellow)	85 – 87.9	¾	¾	1
4 (Red)	88 – 89.9	¾	¾	1
5 (Black)	> 90	1	1	1

* Easy Work – Weapon Maintenance, Walking on hard surface w/ < 30 lb load, guard duty
**Moderate Work – walking loose sand w/ no load, walking hard surface w/ < 40 lb load, physical training
***Hard Work – walking on hard surface w/ ≥ 40 lb load, walking on loose sand w/ load, field assaults

Tips to increase fluids:
Drink by schedule, not by thirst
Drink cooler water
Take water everywhere you go, (Ie: camel back, water bottle, and canteen)
Fluids are also in foods (fruits and vegetables)
Remember: Fluids include juices/sports drinks/water/etc... (anything without caffeine)

Warning
Hourly fluid intake should not exceed 1 ½ quarts.
Daily fluid intake should not exceed 12 quarts.

NUTRIENT NEEDS:

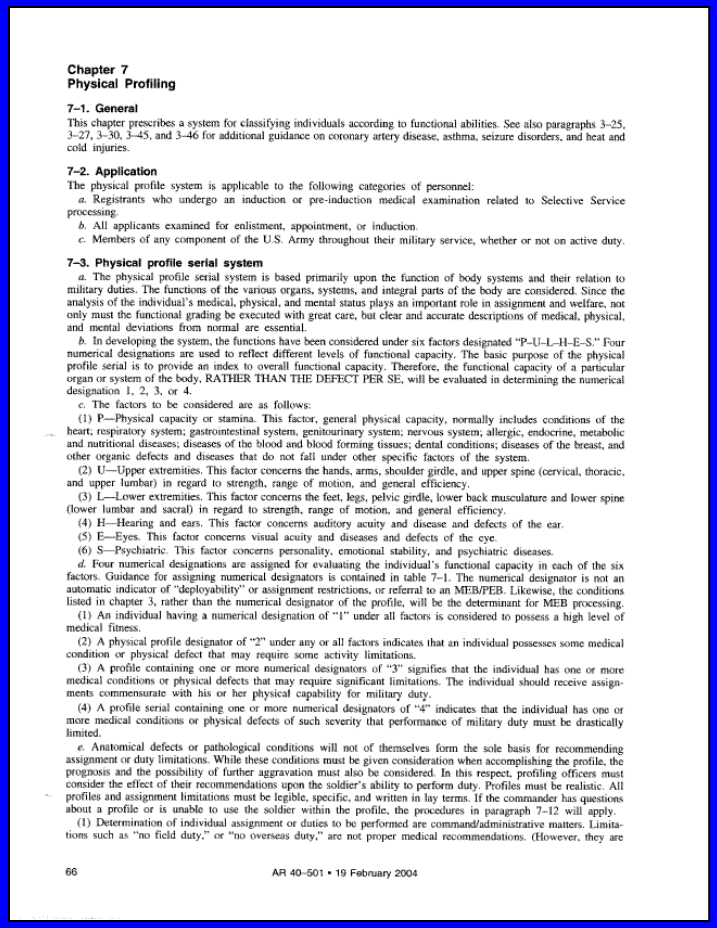
Type of Training	Calories Burned per Day Women	Calories Burned per Day Men
Military Basic Training	2000-3000	3000-4000
Combat Support Hospital Staff in Garrison	2000-2500	3000-3500
Combat Support Hospital Staff in Field	2500-3000	3700-4200

TABLE 2: BASIC NUTRIENT CONTENT OF GENERAL PURPOSE RATION MEALS:

Nutrient	UGR Breakfast*	UGR*** Lunch/Dinner**	MRE
Energy (calories)	1500	1500	1250
Protein	14 % (52 grams)	16% (60 grams)	13% (41 grams)
Carbohydrate	59% (221 grams)	55% (206 grams)	52% (163 grams)
Fat	27% (45 grams)	33% (55 grams)	38% (53 grams)

* Nutrient content reflects the entire meal to include mandatory supplement of 2 slices of bread, 2 (8oz) Milk and 1 Box Cold Cereal
** Nutrient content reflects the entire meal to include mandatory supplement of 2 slices of bread and 8 oz Milk
***Optional enhancements of fresh fruit and salad are not included in the nutrient contents.

Chapter 7, Physical Profiling and Physical Profile Form



Chapter 7
Physical Profiling

7–1. General

This chapter prescribes a system for classifying individuals according to functional abilities. See also paragraphs 3–25, 3–27, 3–30, 3–45, and 3–46 for additional guidance on coronary artery disease, asthma, seizure disorders, and heat and cold injuries.

7–2. Application

The physical profile system is applicable to the following categories of personnel:

a. Registrants who undergo an induction or pre-induction medical examination related to Selective Service processing.

b. All applicants examined for enlistment, appointment, or induction.

c. Members of any component of the U.S. Army throughout their military service, whether or not on active duty.

7–3. Physical profile serial system

a. The physical profile serial system is based primarily upon the function of body systems and their relation to military duties. The functions of the various organs, systems, and integral parts of the body are considered. Since the analysis of the individual's medical, physical, and mental status plays an important role in assignment and welfare, not only must the functional grading be executed with great care, but clear and accurate descriptions of medical, physical, and mental deviations from normal are essential.

b. In developing the system, the functions have been considered under six factors designated "P–U–L–H–E–S." Four numerical designations are used to reflect different levels of functional capacity. The basic purpose of the physical profile serial is to provide an index to overall functional capacity. Therefore, the functional capacity of a particular organ or system of the body, RATHER THAN THE DEFECT PER SE, will be evaluated in determining the numerical designation 1, 2, 3, or 4.

c. The factors to be considered are as follows:

(1) P—Physical capacity or stamina. This factor, general physical capacity, normally includes conditions of the heart; respiratory system; gastrointestinal system, genitourinary system; nervous system; allergic, endocrine, metabolic and nutritional diseases; diseases of the blood and blood forming tissues; dental conditions; diseases of the breast, and other organic defects and diseases that do not fall under other specific factors of the system.

(2) U—Upper extremities. This factor concerns the hands, arms, shoulder girdle, and upper spine (cervical, thoracic, and upper lumbar) in regard to strength, range of motion, and general efficiency.

(3) L—Lower extremities. This factor concerns the feet, legs, pelvic girdle, lower back musculature and lower spine (lower lumbar and sacral) in regard to strength, range of motion, and general efficiency.

(4) H—Hearing and ears. This factor concerns auditory acuity and disease and defects of the ear.

(5) E—Eyes. This factor concerns visual acuity and diseases and defects of the eye.

(6) S—Psychiatric. This factor concerns personality, emotional stability, and psychiatric diseases.

d. Four numerical designations are assigned for evaluating the individual's functional capacity in each of the six factors. Guidance for assigning numerical designators is contained in table 7–1. The numerical designator is not an automatic indicator of "deployability" or assignment restrictions, or referral to an MEB/PEB. Likewise, the conditions listed in chapter 3, rather than the numerical designator of the profile, will be the determinant for MEB processing.

(1) An individual having a numerical designation of "1" under all factors is considered to possess a high level of medical fitness.

(2) A physical profile designator of "2" under any or all factors indicates that an individual possesses some medical condition or physical defect that may require some activity limitations.

(3) A profile containing one or more numerical designators of "3" signifies that the individual has one or more medical conditions or physical defects that may require significant limitations. The individual should receive assignments commensurate with his or her physical capability for military duty.

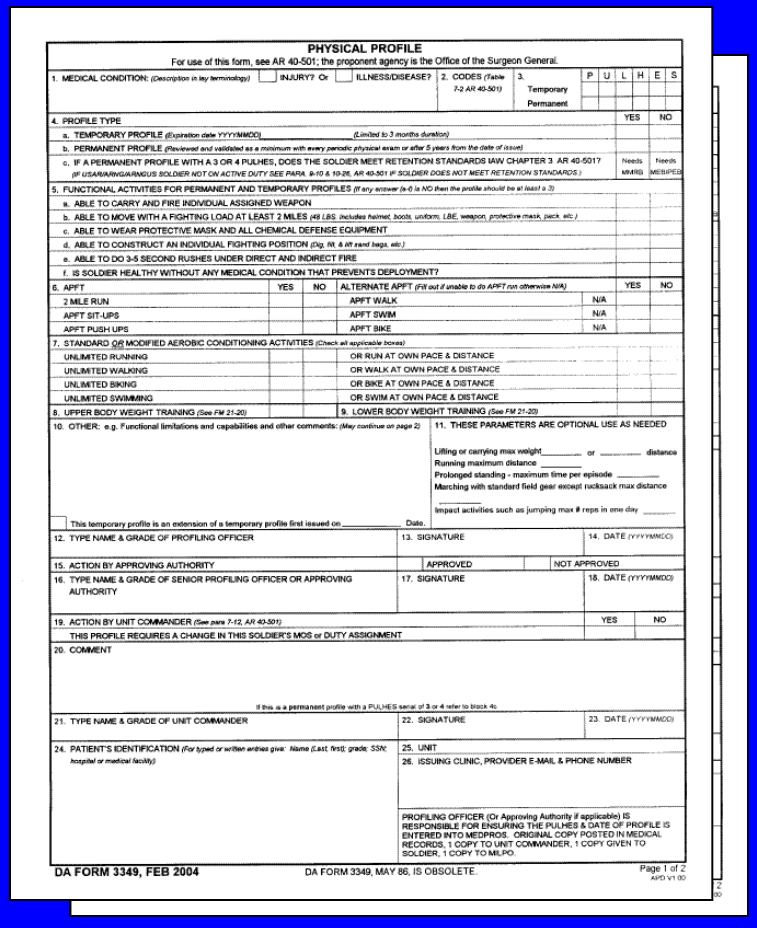
(4) A profile serial containing one or more numerical designators of "4" indicates that the individual has one or more medical conditions or physical defects of such severity that performance of military duty must be drastically limited.

e. Anatomical defects or pathological conditions will not of themselves form the sole basis for recommending assignment or duty limitations. While these conditions must be given consideration when accomplishing the profile, the prognosis and the possibility of further aggravation must also be considered. In this respect, profiling officers must consider the effect of their recommendations upon the soldier's ability to perform duty. Profiles must be realistic. All profiles and assignment limitations must be legible, specific, and written in lay terms. If the commander has questions about a profile or is unable to use the soldier within the profile, the procedures in paragraph 7–12 will apply.

(1) Determination of individual assignment or duties to be performed are command/administrative matters. Limitations such as "no field duty," or "no overseas duty," are not proper medical recommendations. (However, they are

66 AR 40–501 • 19 February 2004

AR 40-501



PHYSICAL PROFILE

For use of this form, see AR 40-501; the proponent agency is the Office of the Surgeon General.

1. MEDICAL CONDITION: *(Description in lay terminology)* ☐ INJURY? Or ☐ ILLNESS/DISEASE? | 2. CODES *(Table 7-2 AR 40-501)* | 3. Temporary / Permanent | P | U | L | H | E | S

4. PROFILE TYPE — YES / NO

a. TEMPORARY PROFILE *(Expiration date YYYYMMDD)* _____ *(Limited to 3 months duration)*

b. PERMANENT PROFILE *(Reviewed and validated as a minimum with every periodic physical exam or after 5 years from the date of issue)*

c. IF A PERMANENT PROFILE WITH A 3 OR 4 PULHES, DOES THE SOLDIER MEET RETENTION STANDARDS IAW CHAPTER 3 AR 40-5017 *(IF USAR/ARNG/ARNGUS SOLDIER NOT ON ACTIVE DUTY SEE PARA. 8-10 & 10-26, AR 40-501 IF SOLDIER DOES NOT MEET RETENTION STANDARDS.)* — Needs MMRB / Needs MEB/PEB

5. FUNCTIONAL ACTIVITIES FOR PERMANENT AND TEMPORARY PROFILES *(If any answer (a-f) is NO then the profile should be at least a 3)*

a. ABLE TO CARRY AND FIRE INDIVIDUAL ASSIGNED WEAPON

b. ABLE TO MOVE WITH A FIGHTING LOAD AT LEAST 2 MILES *(48 LBS. Includes helmet, boots, uniform, LBE, weapon, protective mask, pack, etc.)*

c. ABLE TO WEAR PROTECTIVE MASK AND ALL CHEMICAL DEFENSE EQUIPMENT

d. ABLE TO CONSTRUCT AN INDIVIDUAL FIGHTING POSITION *(Dig, fill, & lift sand bags, etc.)*

e. ABLE TO DO 3-5 SECOND RUSHES UNDER DIRECT AND INDIRECT FIRE

f. IS SOLDIER HEALTHY WITHOUT ANY MEDICAL CONDITION THAT PREVENTS DEPLOYMENT?

6. APFT	YES	NO	ALTERNATE APFT *(Fill out if unable to do APFT run otherwise N/A)*		YES	NO
2 MILE RUN			APFT WALK	N/A		
APFT SIT-UPS			APFT SWIM	N/A		
APFT PUSH UPS			APFT BIKE	N/A		

7. STANDARD OR MODIFIED AEROBIC CONDITIONING ACTIVITIES *(Check all applicable boxes)*				
UNLIMITED RUNNING			OR RUN AT OWN PACE & DISTANCE	
UNLIMITED WALKING			OR WALK AT OWN PACE & DISTANCE	
UNLIMITED BIKING			OR BIKE AT OWN PACE & DISTANCE	
UNLIMITED SWIMMING			OR SWIM AT OWN PACE & DISTANCE	

8. UPPER BODY WEIGHT TRAINING *(See FM 21-20)* — 9. LOWER BODY WEIGHT TRAINING *(See FM 21-20)*

10. OTHER: e.g. Functional limitations and capabilities and other comments: *(May continue on page 2)*

11. THESE PARAMETERS ARE OPTIONAL USE AS NEEDED
Lifting or carrying max weight _____ or _____ distance
Running maximum distance _____
Prolonged standing - maximum time per episode _____
Marching with standard field gear except rucksack max distance _____
Impact activities such as jumping max # reps in one day _____

☐ This temporary profile is an extension of a temporary profile first issued on _____ Date

12. TYPE NAME & GRADE OF PROFILING OFFICER | 13. SIGNATURE | 14. DATE *(YYYYMMDD)*

15. ACTION BY APPROVING AUTHORITY ☐ APPROVED ☐ NOT APPROVED

16. TYPE NAME & GRADE OF SENIOR PROFILING OFFICER OR APPROVING AUTHORITY | 17. SIGNATURE | 18. DATE *(YYYYMMDD)*

19. ACTION BY UNIT COMMANDER *(See para 7-12, AR 40-501)* — YES / NO
THIS PROFILE REQUIRES A CHANGE IN THIS SOLDIER'S MOS or DUTY ASSIGNMENT

20. COMMENT
If this is a permanent profile with a PULHES serial of 3 or 4 refer to block 4c.

21. TYPE NAME & GRADE OF UNIT COMMANDER | 22. SIGNATURE | 23. DATE *(YYYYMMDD)*

24. PATIENT'S IDENTIFICATION *(For typed or written entries give: Name (Last, first); grade; SSN; hospital or medical facility)* | 25. UNIT | 26. ISSUING CLINIC, PROVIDER E-MAIL, & PHONE NUMBER

PROFILING OFFICER (Or Approving Authority if applicable) IS RESPONSIBLE FOR ENSURING THE PULHES & DATE OF PROFILE IS ENTERED INTO MEDPROS. ORIGINAL COPY POSTED IN MEDICAL RECORDS, 1 COPY TO UNIT COMMANDER, 1 COPY GIVEN TO SOLDIER, 1 COPY TO MILPO.

DA FORM 3349, FEB 2004 DA FORM 3349, MAY 86, IS OBSOLETE. Page 1 of 2 APD V1 00

DA Form 3349

Pharmacy Information in DM binder

Insulin Storage and Stability

Manufacturer Vials and Pens

In response to inquires from patients and healthcare providers, we have gathered storage and stability information from insulin manufacturers and the most current medical literature available. Varying non-referenced or clinically supported sources exist which can lead to confusion and possibly patient harm. The following charts serve as a referenced guide to the stabilities of insulin vials and pens after initial use and predrawn insulin syringes. Remember, as future information becomes available, you will need to validate the reference and update your clinical references accordingly. Information current as of May 30, 2002.

Vial	Unopened refrigerated	Unopened room temp	Seal punctured, refrig/room temp*
Humulin R[1]	labeled exp date	28 days	28 days
Humulin N[1]	labeled exp date	28 days	28 days
Humulin L[1]	labeled exp date	28 days	28 days
Humulin U[1]	labeled exp date	28 days	28 days
Humulin 70/30[1]	labeled exp date	28 days	28 days
Humalog[2]	labeled exp date	28 days	28 days
Humalog 75/25[2]	labeled exp date	28 days	28 days
Novolin R[3]	labeled exp date	30 days	30 days
Novolin N[3]	labeled exp date	30 days	30 days
Novolin L[3]	labeled exp date	30 days	30 days
Novolin 70/30[3]	labeled exp date	30 days	30 days
Novolog[4]	labeled exp date	28 days	28 days
Lantus[4]**	labeled exp date	28 days	28 days

**Potency loss may occur after the bottle has been in use for >1 month, especially if stored at room temperature.[1]*
***Lantus should not be mixed with other insulin products. No data is available on stability of predrawn Lantus syringes.[4]*

Pen	Unopened refrigerated	Unopened room temp	In use* room temp
Humulin N[1]	labeled exp date	14 days	14 days
Humulin 70/30[1]	labeled exp date	10 days	10 days
Humalog[2]	labeled exp date	28 days	28 days
Humalog 75/25[2]	labeled exp date	10 days	10 days
Novolin R[3]	labeled exp date	28 days	28 days
Novolin N[3]			
3ml cartridge	labeled exp date	14 days	14 days
1.5ml cartridge	labeled exp date	7 days	7 days
Novolin 70/30[3]			
3ml cartridge	labeled exp date	10 days	10 days
1.5ml cartridge	labeled exp date	7 days	7 days
Novolog Penfill[4]	labeled exp date	28 days	28 days

**Manufacturer recommends not to refrigerate pens in use*

Insulin Syringes Predrawn from Manufacturer Vials

Novolin and Humulin products as a single entity predrawn syringe can be stored for 30 and 21 days, respectively, under refrigeration.[5]

No data is available on the stability of Humalog and Novolog products as a single entity predrawn syringe.[5]

Insulin Product	Combined with...	Stability with refrigeration	Comments
Novolin R[3,5]	Novolin N	30 days	—
Novolin R[1,5]	Novolin L	30 days	Standardize the interval between mixing and injection (~24 hours)
NovoLog[5]	Novolin N	Use immediately	NovoLog should be drawn up first

**NPH or Velosulin BR should not be mixed with Lente or Ultralente insulin*
***Store predrawn syringes in vertical position with needle pointing up to prevent clogging of the needle*

Insulin Product	Combined with...	Stability with refrigeration	Comments
Humulin R[1,5]	Humulin N	21 days	—
Humulin R[1,5]	Humulin L or U	21 days	Standardize the interval between mixing and injection (~24 hours)
Humalog[5]	Humulin N or L or U	Use Immediately	Humalog should be drawn up first

**Humulin N should not be mixed in the same syringe with Humulin L or U*
***Store predrawn syringes in vertical position with needle pointing up to prevent clogging of the needle*

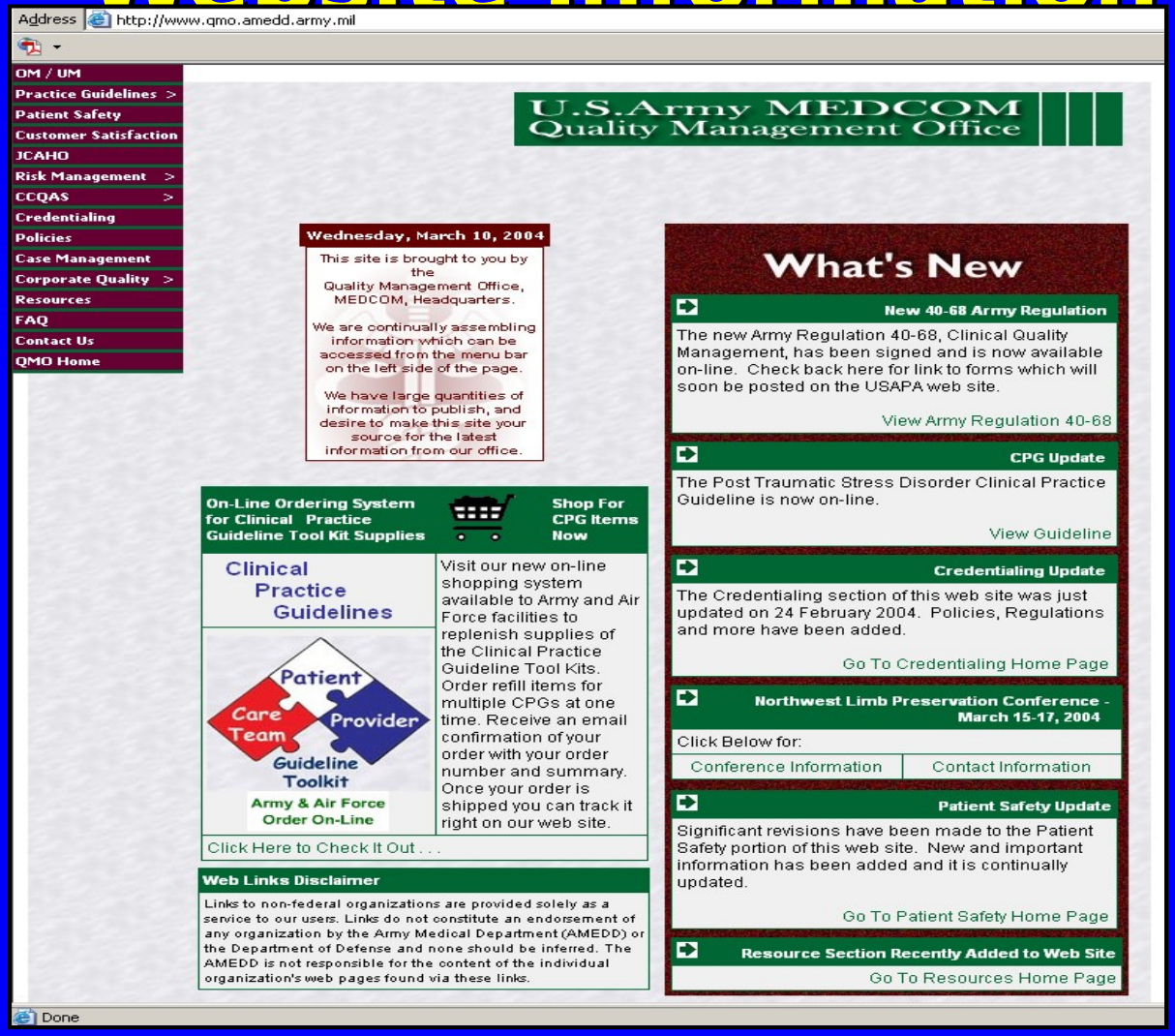
References:

1. American Diabetes Association. Insulin Administration. *Diabetes Care*. 2002;25(Suppl 1):S112-115.
2. Peters AL, Davidson MB. Effect of storage on action of NPH and regular insulin mixtures. *Diabetes Care*. 1987;10(6):799-800.
3. Drass J. What you need to know about insulin injections. *Nursing 92*. 1992;22(11):40-43.
4. Tarr BD, Campbell RK, Workman TM. Stability and sterility of biosynthetic human insulin stored in plastic insulin syringes for 28 days. *Amer J Hosp Pharm*. 1991;48:2631-2634.
5. Information on specific insulin products were gathered from most recent package inserts and communication with manufacturing companies including Aventis, Eli Lilly and Company, and Novo Nordisk.

Provided as a service of

Bohlman Drugstore, Inc
1028 Wisconsin Ave. Boscobel, WI 53805 608-375-4466
This table also available on the PSW web site, www.pswi.org or by calling Bohlman Drugstore.

MEDCOM Clinical Practice Guideline Website Information


Address http://www.qmo.amedd.army.mil
OM / UM
Practice Guidelines >
Patient Safety
Customer Satisfaction
JCAHO
Risk Management >
CCQAS >
Credentialing
Policies
Case Management
Corporate Quality >
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U.S.Army MEDCOM
Quality Management Office
Wednesday, March 10, 2004
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We are continually assembling information which can be accessed from the menu bar on the left side of the page.
We have large quantities of information to publish, and desire to make this site your source for the latest information from our office.
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What's New
New 40-68 Army Regulation
The new Army Regulation 40-68, Clinical Quality Management, has been signed and is now available on-line. Check back here for link to forms which will soon be posted on the USAPA web site.
View Army Regulation 40-68
CPG Update
The Post Traumatic Stress Disorder Clinical Practice Guideline is now on-line.
View Guideline
Credentialing Update
The Credentialing section of this web site was just updated on 24 February 2004. Policies, Regulations and more have been added.
Go To Credentialing Home Page
Northwest Limb Preservation Conference - March 15-17, 2004
Click Below for:
Conference Information
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Patient Safety Update
Significant revisions have been made to the Patient Safety portion of this web site. New and important information has been added and it is continually updated.
Go To Patient Safety Home Page
Resource Section Recently Added to Web Site
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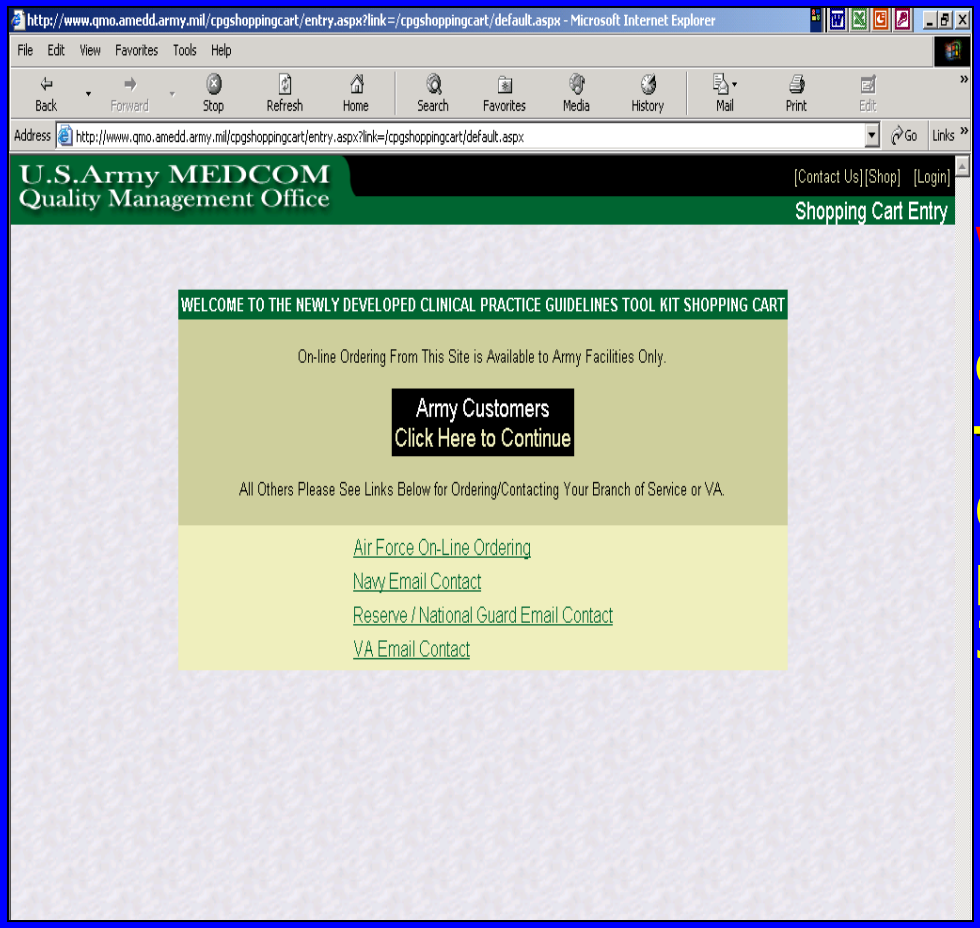
www.QMO.amedd.army.

CPG Toolkit Materials
On-line Shopping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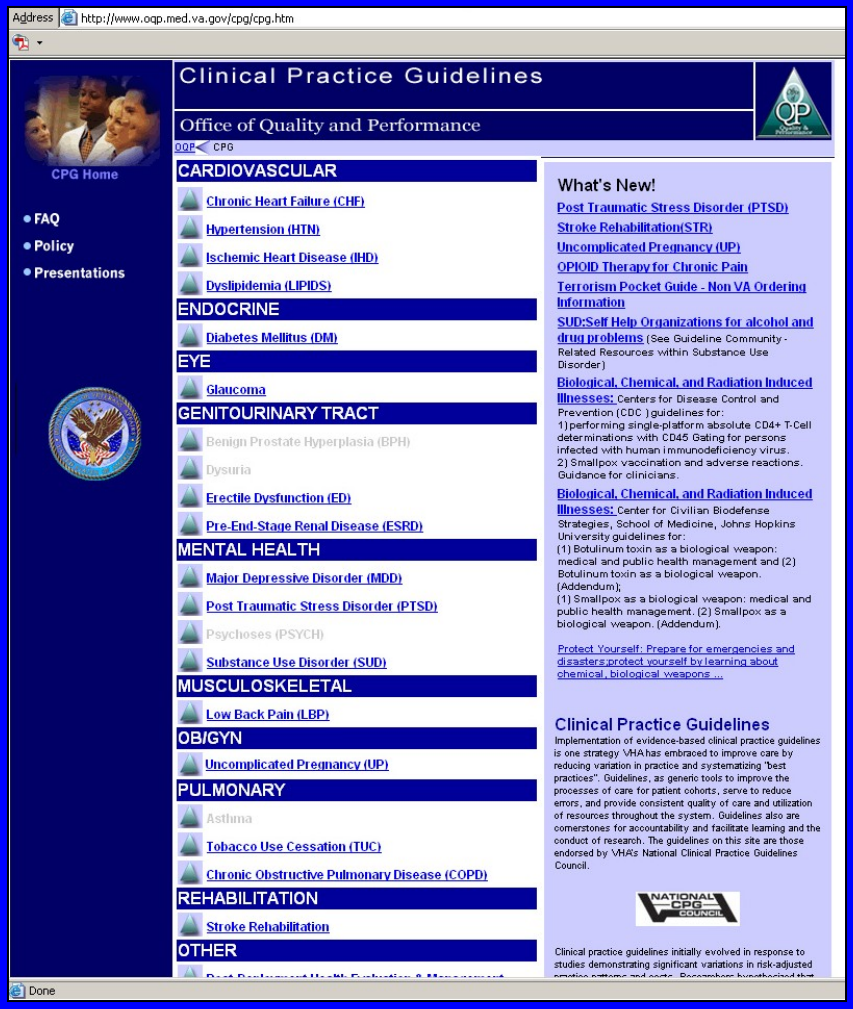
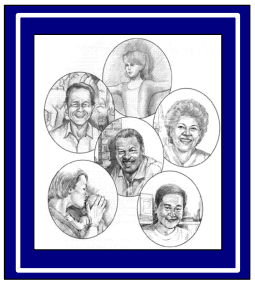

Address http://www.oqp.med.va.gov/cpg/cpg.htm
Clinical Practice Guidelines
Office of Quality and Performance
OQP CPG
CPG Home
FAQ
Policy
Presentations
CARDIOVASCULAR
Chronic Heart Failure (CHF)
Hypertension (HTN)
Ischemic Heart Disease (IHD)
Dyslipidemia (LIPIDS)
ENDOCRINE
Diabetes Mellitus (DM)
EYE
Glaucoma
GENITOURINARY TRACT
Benign Prostate Hyperplasia (BPH)
Dysuria
Erectile Dysfunction (ED)
Pre-End-Stage Renal Disease (ESRD)
MENTAL HEALTH
Major Depressive Disorder (MDD)
Post Traumatic Stress Disorder (PTSD)
Psychoses (PSYCH)
Substance Use Disorder (SUD)
MUSCULOSKELETAL
Low Back Pain (LBP)
OB/GYN
Uncomplicated Pregnancy (UP)
PULMONARY
Asthma
Tobacco Use Cessation (TUC)
Chronic Obstructive Pulmonary Disease (COPD)
REHABILITATION
Stroke Rehabilitation
OTHER
What's New!
Post Traumatic Stress Disorder (PTSD)
Stroke Rehabilitation(STR)
Uncomplicated Pregnancy (UP)
OPIOID Therapy for Chronic Pain
Terrorism Pocket Guide - Non VA Ordering Information
SUD:Self Help Organizations for alcohol and drug problems (See Guideline Community - Related Resources within Substance Use Disorder)
Biological, Chemical, and Radiation Induced Illnesses: Centers for Disease Control and Prevention (CDC) guidelines for:
1) performing single-platform absolute CD4+ T-Cell determinations with CD45 Gating for persons infected with human immunodeficiency virus.
2) Smallpox vaccination and adverse reactions. Guidance for clinicians.
Biological, Chemical, and Radiation Induced Illnesses: Center for Civilian Biodefense Strategies, School of Medicine, Johns Hopkins University guidelines for:
(1) Botulinum toxin as a biological weapon: medical and public health management and (2) Botulinum toxin as a biological weapon. (Addendum);
(1) Smallpox as a biological weapon: medical and public health management. (2) Smallpox as a biological weapon. (Addendum).
Protect Yourself: Prepare for emergencies and disasters;protect yourself by learning about chemical, biological weapons ...
Clinical Practice Guidelines
Implementation of evidence-based clinical practice guidelines is one strategy VHA has embraced to improve care by reducing variation in practice and systematizing "best practices". Guidelines, as generic tools to improve the processes of care for patient cohorts, serve to reduce errors, and provide consistent quality of care and utilization of resources throughout the system. Guidelines also are cornerstones for accountability and facilitate learning and the conduct of research. The guidelines on this site are those endorsed by VHA's National Clinical Practice Guidelines Council.
NATIONAL CPG COUNCIL
Clinical practice guidelines initially evolved in response to studies demonstrating significant variations in risk-adjusted
Done

www.oqp.med.va.gov/cpg/cpg.h

Diabetes Mellitus Clinical Practice Guideline Directory Information

Directory of Diabetes Organizations and Related Websites



This directory is an expanded list of government agencies, voluntary associations, and private organizations that provide diabetes information and resources.

These organizations and related websites offer educational materials and support to people with diabetes and the general public. Other sites are specific to health care professionals.

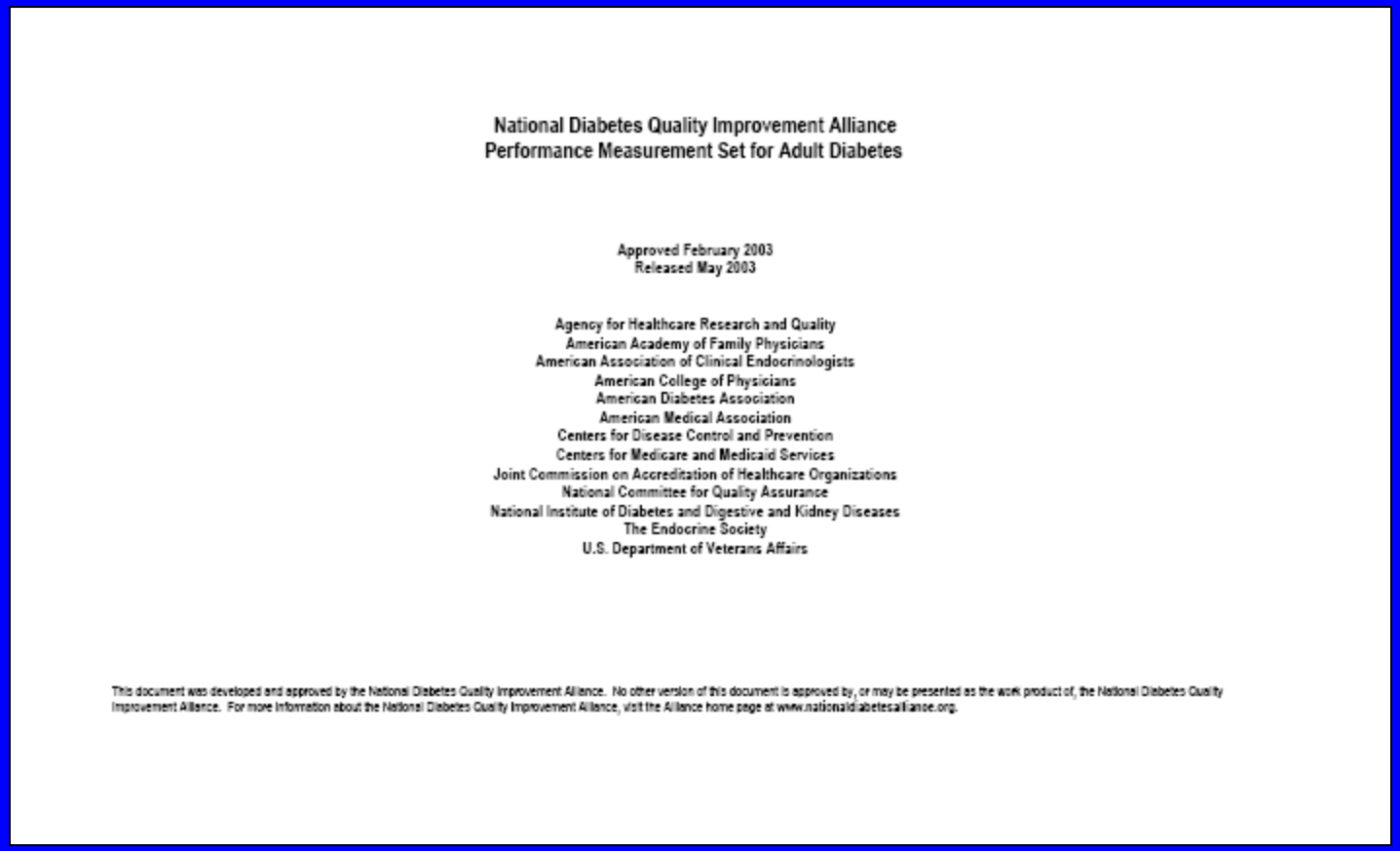
Updated and current as of March 2004.

Websites for Additional Information on Diabetes Mellitus and Related Topics

Diabetes Population Level Metrics

- % with one or more A1c test(s)
- % with with A1c > 9.0% (poor control)
- % with with at least one LDL-C test
- % with % with most recent LDL-C < 130 mg/dl
- % with at least one test for microalbumin or who had evidence of medical attention for existing nephropathy
- % with dilated eye exam or evaluation of retinal photographs by an eye care specialist during reporting year or during the prior year if patient low risk (must have all three: not on insulin, A1c < 8%, no evidence of retinopathy in prior year)
- % with comprehensive foot exam
- % with BP < 140/90 mm Hg
- % screened and documented for tobacco use

National Diabetes Quality Improvement Alliance Performance Measurement Set



National Diabetes Quality Improvement Alliance
Performance Measurement Set for Adult Diabetes

Approved February 2003
Released May 2003

Agency for Healthcare Research and Quality
American Academy of Family Physicians
American Association of Clinical Endocrinologists
American College of Physicians
American Diabetes Association
American Medical Association
Centers for Disease Control and Prevention
Centers for Medicare and Medicaid Services
Joint Commission on Accreditation of Healthcare Organizations
National Committee for Quality Assurance
National Institute of Diabetes and Digestive and Kidney Diseases
The Endocrine Society
U.S. Department of Veterans Affairs

This document was developed and approved by the National Diabetes Quality Improvement Alliance. No other version of this document is approved by, or may be presented as the work product of, the National Diabetes Quality Improvement Alliance. For more information about the National Diabetes Quality Improvement Alliance, visit the Alliance home page at www.nationaldiabetesalliance.org.

What the IHI says..

- **Embed Evidence-Based Guidelines in the Care Delivery System**
- **Consider conducting a baseline audit (using the MHSPHP) to benchmark your current practice against agreed upon guidelines.**
- **Use flow sheets, pathways,or checklists to embed guidelines into daily practice. The guidelines include triggers for care.**
- **Link guidelines to the information system to provide prompts.**
- **Remove barriers identified with previous guidelines.**

What the IHI says..

- **Tips**
- **Don't reinvent the wheel! Use evidence-based guidelines. (Use VA/DoD DM CPG and if want stricter targets then agree on them)**
- **Involve a provider champion**
- **Set clear expectations and timelines**

What the IHI says..

- To get buy-in from influencial naysayers, involve them in the process.
- Remove barriers to guideline implementation, such as slow turnaround time for lab results, inertia.
- Don't get mirred down in complex algorithms or standards of care.
- Talk to other organizations that have already customized guidelines to get the fastest process in place.
- Collect only the data that are needed.

What the IHI says..

- Have providers abstract a random sample of their own charts. This helps them discover the gap between what they know is good practice and what they actually do. Try a "lunch and learn" session to achieve this.
- Try to integrate the chart audit with development of the registry. Talk to other organizations that have already customized guidelines.
- The patient encounter form may also be know as a visit note, flow sheet, treatment planning form, order entry form, etc.
- Make it as hard as possible to ignore the guideline. Make it easier to do the right thing (e.g., check a box instead of having to write out a lot of information).
- Make it efficient to follow guidelines. Physicians will be more likely to use them if they save time.

What the IHI says..

- Make it hard to forget to follow guidelines: work with the lab to develop staged testing protocols (e.g., automatic microalbumin measurement when an annual screening U/A is negative for protein to avoid recall of patient/resubmission of urine).
- Ask teams that are already practicing evidence-based medicine to spread the word. If a team is not practicing this way, have them visit another clinic that is.
- Think about why guideline implementation is not working:
- Lack of awareness
- Lack of agreement
- External factors (time, money, resource availability)
- Inertia
- Discuss which of these factors is playing a role. You may have to address multiple issues simultaneously.